COMMONWEALTH OF VIRGINIA
Department of Health

ROBERT B. STROUBE, M.D., M.P.H.
STATE HEALTH COMMISSIONER

DOUGLAS R. HARRIS, J.D.
ADJUDICATION OFFICER

**REPORT AND RECOMMENDATION TO
THE STATE HEALTH COMMISSIONER
REGARDING CERTIFICATE OF PUBLIC NEED (COPN)
REQUEST NUMBER VA-6361, SUBMITTED BY
BON SECOURS - RICHMOND HEALTH SYSTEM
IN 1999 FOR THE PROPOSED REPLACEMENT AND
RELOCATION OF STUART CIRCLE HOSPITAL (SCH),
CITY OF RICHMOND, WITH CONSTRUCTION OF ST. FRANCIS
MEDICAL CENTER (SFMC), COUNTY OF CHESTERFIELD**

**IN ACCORDANCE WITH A DECISION OF
the Virginia Court of Appeals
Disposing of an Appeal Relating to this Matter,
Dated October 9, 2001**

**PURSUANT TO AN ORDER OF
the Circuit Court for the County of Chesterfield,
Remanding the Matter to the State Health Commissioner
for Further Proceedings, Dated June 17, 2002**

**FOLLOWING THE SETTING ASIDE OF
COPN Number VA-03485 on September 6, 2002,**

**WITH BENEFIT OF
Further Administrative Proceedings, Including
Written and Oral Argument and Evidence Presented by
HCA - Chippenham & Johnston-Willis Hospitals, Inc. (CJW),
A Party Showing Good Cause, and Additional Written and Oral
Evidence and Rebuttal Presented by the Applicant**

I. FINDINGS OF FACT.

A. Authority; Procedural and Contextual Background.

1. Sections 32.1-102.1 and 32.1-102.3 of the Code of Virginia require that a "project," as defined therein to include, among other things, the "[e]stablishment of a medical care facility," must be approved through issuance of a certificate of public need (COPN or certificate) issued by the State Health Commissioner (Commissioner).

2. Virginia regulation, *viz.*, the State Medical Facilities Plan [SMFP, contained in the Virginia Administrative Code (VAC) at 12 VAC 5-230-10 *et seq*.], adopted by the State Board of Health, contains standards and provisions with which the Commissioner shall review applications for a COPN, such as the present one which seeks authorization to replace and relocate a hospital. The SMFP is substantially unchanged since its adoption in 1992.

3. Pursuant to Subsection B of Section 32.1-102.7 of the Code, the Central Virginia Health Planning Agency (CVHPA) serves Virginia's Health Planning Region (HPR) IV by reviewing projects proposed for location within the boundaries of HPR IV. HPR IV includes Virginia's planning district (PD) 15, which is comprised of the City of Richmond and the County of Chesterfield, along with other localities proximate to Richmond but less relevant to the present matter, including the counties of Hanover, Goochland, Henrico, New Kent, Powhatan and Charles City. PD 15 is generally understood to cover the greater and extended Richmond metropolitan area.

4. Bon Secours - Stuart Circle Hospital, Inc., a Virginia not-for-profit, nonstock corporation exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, owns Bon Secours - Stuart Circle Hospital (SCH, or Stuart Circle), formerly operational and located on Monument Avenue, in the City of Richmond. The sole member of Bon Secours - Stuart Circle Hospital, Inc., is Bon Secours Richmond Health System (BSRHS or Bon Secours), which also owns several other similar corporations, and by extension, other acute care hospitals in PD 15, including St. Mary's Hospital in Henrico, Richmond Community Hospital in Richmond, and Memorial Regional Medical Center (MRMC) in Hanover. BSRHS enjoys the same 501(c)(3) status.

5. Bon Secours - St. Francis Medical Center, Inc., is an affiliate of BSRHS, newly formed to carry out the planned construction, establishment and operation of an additional hospital, to be known as St. Francis Medial Center (SFMC), in the event the Commissioner authorizes the project through the issuance of a COPN following this recommendation.

6. Stuart Circle was a 153-bed general acute care hospital, the core of which was built in 1912 and augmented with additions in 1919, 1954, 1957 and 1978. It included 135 medical-surgical beds, eight intensive care beds, and 10 chemical dependency beds, along with five operating rooms.

7. On July 1, 1999, BSRHS submitted an application for a COPN. The application sought approval of a project to replace and relocate Stuart Circle to a new facility – SFMC, to be built on an

unimproved parcel of land approximately 25 acres in size, located in CenterPointe, southwestern Chesterfield County (the St. Francis project).

8. On September 21, 1999, CVHPA hosted a public hearing on the St. Francis project in order to consider citizens' comments, pursuant to Virginia law. On October 6, 1999, the health planning staff of CVHPA issued a written report analyzing the project. On the same day and pursuant to authorizing law, noted above, the board of directors of CVHPA voted to recommend approval of the project, conditioned on the agreement of BSRHS to (i) limit the number of operating rooms at SFMC, (ii) provide a specified minimum level of medical care to indigent persons, and (iii) collaborate with others to find a suitable reuse plan for the building within which Stuart Circle then operated. [The Capital Area Health Advisory Council (CAHAC) exists pursuant to bylaws of CVHPA, consists of consumers and health professionals and internally advises CVHPA by reviewing projects proposed for location in PD 15; CAHAC, like CVHPA, continues to recommend conditional approval of the St. Francis project.]

9. Chippenham & Johnston-Willis Hospitals, Inc. (CJW), is ultimately owned by HCA, Inc., a for-profit Tennessee corporation owning and operating approximately 200 facilities across the U.S., and in England and Switzerland. On October 29, 1999, CJW petitioned the Commissioner pursuant to Subsections D and G of Section 32.1-102.6 of the Code of Virginia to become a person showing "good cause," a status that would, in effect, allow CJW to participate as a party in an administrative proceeding, *i.e.*, an informal fact-finding conference (IFFC), at which the St. Francis project would be heard to determine whether it would meet a public need under Virginia law.

10. CJW owns Chippenham Hospital and Johnston-Willis Hospital. These two facilities are referred to together as CJW Medical Center. Chippenham Hospital, or the Chippenham campus of CJW Medical Center, lies in the City of Richmond, south of the James River, near the boundary with Chesterfield County, and is easily accessed by Chippenham Parkway (State Primary Route 150) and Powhite Parkway (State Primary Route 76, which crosses the James River, connecting with Interstate 195). The Chippenham campus is 8.4 miles from the site upon which SFMC would be constructed. Johnston-Willis Hospital, or the Johnston-Willis campus of CJW, lies in Chesterfield County, to the west of the Chippenham campus, and near Midlothian Turnpike (U.S. Route 60), Courthouse Road (State Secondary Route 653) and Huguenot Road (State Primary Route 147, which crosses the James River, connecting with Cary Street). The Johnston-Willis campus is 7.2 miles from the site proposed for SFMC. Chippenham and Powhite parkways are multilane, access-controlled, divided highways.

11. On November 5, 1999, BSRHS submitted a written response including attachments detailing its opposition to the CJW's good cause petition.

12. On November 9, 1999, the Commissioner's then-serving adjudication officer conducted two IFFCs related to the St. Francis project. The first IFFC allowed CJW to (i) assert its evidence and argument that good cause exists, and (ii) present orally and discuss its analysis of the St. Francis project, while the second IFFC allowed BSRHS to present orally and discuss its application seeking approval of the St. Francis project.

13. After reviewing a written analysis of the good cause petition prepared by the adjudication officer, E. Anne Peterson, M.D., M.P.H., then serving as Commissioner, denied the petition seeking to show good cause submitted by CJW on November 15, 1999.

14. On December 16, 1999, Dr. Peterson announced her intention to approve the St. Francis project conditionally. Dr. Peterson based her intention on a general finding that the project would meet a public need, supported by a written recommendation prepared by the Commissioner's adjudication officer. Dr. Peterson conditioned her intended approval on the agreement of BSRHS to heed several conditions, designed to mirror those proffered by CVHPA, discussed above, and to tailor the project as she had determined appropriate.

15. BSRHS subsequently submitted its written agreement to the Commissioner's conditions, and, on December 29, 1999, the Commissioner issued COPN Number VA-03485, as authorization for the implementation and construction of SFMC, conditioned as agreed, in exercise of the authority and discretion granted her by law.

16. CJW submitted written notice of an appeal to the Commissioner pursuant to Rule 2A:2 of the Rules of the Virginia Supreme Court, and thereafter appealed the denial of its good cause petition to Chesterfield County Circuit Court. On November 3, 2000, the circuit court affirmed the Commissioner's decision to authorize SFMC by issuing a COPN, reflected in an order entered on December 1, 2000. CJW appealed further to the Virginia Court of Appeals, which reversed the circuit court, finding that the CVHPA had committed a "material mistake of law," one of the bases provided by law upon which CJW could achieve good cause status, in recommending that the St. Francis project be approved. *See Chippenham & Johnston-Willis Hospitals, Inc., v. E. Anne Peterson, M.D., State Health Commissioner, et al.*, 36 Va. App. 469, 553 S.E. 2d 133 (2001).

17. Dr. Peterson (who served as Commissioner until November 5, 2001) and BSRHS, separately, petitioned the Supreme Court of Virginia to review the Court of Appeals decision. The Supreme Court denied the petition finding "no reversible error in the judgment."

18. On remand from the Court of Appeals, the circuit court entered an order on June 17, 2002, remanding the matter regarding the St. Francis project to the Commissioner for further administrative proceedings.

19. The court's order included a directive to the Commissioner (i) to reverse the decision that rejected the petition of CJW attempting to demonstrate good cause, and (ii) to conduct further proceedings consistent with the opinion set forth in the Court of Appeals decision.

20. On September 6, 2002, Robert B. Stroube, M.D., M.P.H., the current Commissioner, wrote a letter to BSRHS and CJW announcing his decision to (i) reverse the decision rejecting the good cause petition submitted by CJW, (ii) set aside the issuance of COPN Number VA-03485, which authorized the St. Francis project, and (iii) reopen the administrative record, as called for by Court of Appeals, to allow further proceedings before the Department of Health, the state agency directed by the Commissioner, consistent with the Court of Appeals decision.

21. On September 12, 2002, the Commissioner's current adjudication officer, *i.e.*, the person writing this recommendation, hosted a preliminary conference with counsel to CJW and BSRHS and, at that conference, gained counsel's general accession to specific written guidelines (proposed and distributed beforehand) for the conduct of a subsequent two-day IFFC to review this administrative matter in accordance with the judicial review.

22. On September 26 and 27, 2002, the Commissioner's current adjudication officer convened an IFFC regarding the St. Francis project, with both CJW and BSRHS participating as parties to the proceeding. Both CJW and BSRHS were represented by counsel at this two-day IFFC and were afforded ample opportunity to present substantial argument and evidence, including the testimony of a total of nine witnesses in support of their respective positions, some recognized as experts in various health-related fields.

23. CJW presented the testimony of, among other witnesses, Richard F. Tompkins, Ed.D., president of The First Chesapeake Group and a recognized expert in health care planning, and Gerard F. Anderson, Ph.D., a professor at Johns Hopkins University and recognized author and expert in health policy and management. BSRHS presented the testimony of, among other witnesses, Deborah S. Kolb, Ph.D., vice-president of Jennings Ryan & Kolb, an Atlanta-based consulting firm specializing in health care management, and a recognized author and expert in that area, and Monica G. Noether, Ph.D., vice-president of Charles River Associates, a Boston-based consulting firm specializing in health care economics and planning, and a recognized author and expert in the areas of antitrust analysis and the effects of competition in the health care marketplace.

24. Both CJW and BSRHS were afforded the opportunity to, and did, submit written information and argument subsequent to the two-day IFFC, including additional documentation, proposed findings of fact and conclusions of law, and rebuttal until the date on which the record in the matter closed, which fell, by agreement of the parties and the adjudication officer, on November 8, 2002.

25. At the 2002 IFFC, BSRHS urged the Commissioner to act pursuant to Subsection A of Section 32.1-102.3 of the Code of Virginia and set aside three specific provisions of the SMFP, discussed in detail below, with which the St. Francis project does not comply.

B. Prior Decisions of the Commissioner Regarding Applications to Replace and Relocate Hospitals.

26. In 1977, James P. Kenley, M.D., State Health Commissioner, approved a proposal to replace and relocate Mary Immaculate Hospital, in the City of Newport News, PD 21, to another site in that city. In a written decision, issued June 17, 1977, Dr. Kenley stated that

> Mary Immaculate Hospital's application for a [COPN] has generated a degree of controversy which underscores the public's concern over health care and which demonstrates the vitality of the . . . review process. . . .

> Overbedding, such as exists in the Peninsula [essentially PD 21], is often-times a decisive factor in the determination of public need, and in other circumstances, it might dictate the closure of a facility which required a [COPN] for continued operation. . . . Sufficient convincing evidence has been presented to demonstrate that, without a [COPN], Mary Immaculate Hospital cannot continue as a viable health care provider. Such an asset to the health care of a community should not be lightly discarded. In this instance, other factors exist which assume greater importance than the number of excess beds.
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> Mary Immaculate Hospital is presently located near another general hospital in an older section of the city which is experiencing a decrease in population whereas other areas are growing. No longer is it feasible for two hospitals to operate in that area. It is, however, desirable to optimize the conditions so that one can continue to exist and to serve the population which lives in the immediate vicinity. Such a result can be attained if Mary Immaculate moves to a new location.
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> Similarly, relocation is a better alternative than is renovation at the present site because, in my judgment, no amount of renovation will insure that utilization of Mary Immaculate Hospital will improve. . . . [C]omparing the costs of relocation and its attendant advantages to the costs of renovation and its lack of advantages, relocation is better health planning. . . . *Relocation does not increase the number of beds but simply insures a better distribution of existing beds in the Peninsula.* [Emphasis added.]

27. Also in 1977, Dr. Kenley approved a proposal to replace and relocate Johnston-Willis Hospital, in the City of Richmond, to a site in northern Chesterfield County which serves as one of the present campuses of CJW Medical Center, owned by the good cause party to the present proceedings. In a written decision, issued December 22, 1977, Dr. Kenley stated that

> [a]lthough the James River is not an insurmountable barrier to access to other facilities, it does limit the number of alternative routes available. The rapid growth of Chesterfield County is expected to continue in the near future and . . . the demands of that population will place an increasing burden on Chippenham Hospital, currently the only hospital in . . . Richmond . . . south of the river. . . .
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> There is evidence to indicate that now or in the near future, Johnston-Willis Hospital . . . will require substantial renovation if it is to meet life safety code requirements and continue as a viable health care provider. Renovation on site will perpetuate the existing maldistribution of hospital beds in the Richmond area. Relocation will . . . improve the access to care for the residents of Chesterfield, Powhatan and Amelia counties. . . .
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> The proposed reduction of operating beds in an overbedded area will increase the health system's efficiency.

28. In 1983, Dr. Kenley approved a proposal to replace and relocate Commonwealth Hospital within Fairfax County, PD 8. Upon relocation, this hospital became Fair Oaks Hospital, now affiliated with the Inova Health System. In a written decision, issued September 14, 1983, Dr. Kenley stated that

> [i]nitially, the issue of replacement is a most important matter because northern Virginia has an excess of hospital beds. Given that excess, many would conclude that the better health planning approach would be to deny Commonwealth Hospital a certificate to replace which would eventually compel the hospital to close as health and safety problems became insolvable.
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> I do not quarrel with the fact that the health care system in northern Virginia does not need as many hospitals as it now has. However, *the statute does not specifically authorize me to compel owners of existing facilities to go out of business eventually by refusing them certificates to replace. In my judgment, such an intent would have been specifically set forth by the General Assembly. Thus, I have for many years construed and administered the law to allow a facility's owners to obtain a certificate to replace when I was satisfied that the replacement was necessary and when the applicant's proposal was reasonable in scope, in location and in cost.* In other words, the statutory criteria in Section 32.1-102.3 [of the Code] must be evaluated with a recognition for the unique situation that exists when a facility's owners demonstrate the need to replace. [Emphasis added.]

29. In 1984, Dr. Kenley approved a proposal to replace and relocate Circle Terrace Hospital to Reston, in Fairfax County. (This hospital later became and remains HCA - Reston Hospital.) In a written decision, issued February 27, 1984, following protracted proceedings and negotiations resulting in a reduction of scope for the replacement facility, Dr. Kenley noted that "[t]he proposed project will upgrade an existing facility that has an inadequate physical plant in terms of age and size to support its functions in an acceptable manner."

30. In 1993, Dr. Stroube, then serving his first term as Commissioner, approved a proposal to replace and relocate Richmond Memorial Hospital (RMH) to a site in Hanover County. This hospital became Memorial Regional Medical Center (MRMC), which currently has a total of 205 acute care beds – consisting of 151 medical-surgical beds, 29 intensive care and critical care beds and 15 obstetric beds. In a report and recommendation to the Commissioner dated November 22, 1993, the Department's professional health planning staff noted that

> [t]his project is not fully consistent with the . . . [SMFP provisions relating to the off-site replacement of existing services, in Subsection B of 12 VAC 5-240-30, and the use of underutilized beds, in Subsection A of 12 VAC 5-240-50]. Replacement of RMH's beds is not necessary to correct life safety or building code deficiencies and beds are being relocated to a new location with underutilized beds available within ten miles. . . . [The Department's staff] believes that these areas of non-compliance are off-set, to some extent, by the large amount of analysis presented by the applicant concerning the functional deficiencies of its existing physical plant which support the cost-

effectiveness of the replacement alternative and the fact that RMH is substantially down-sizing through its replacement proposal.

C. Findings Directly Relating or Relevant to Consideration of the Proposed Project.

31. BSRHS purchased Stuart Circle in 1994. In 1997, BSRHS submitted two applications for COPNs seeking authorization for improvements at Stuart Circle. One sought to convert ten substance abuse-chemical dependency beds to psychiatric beds, the other sought to introduce nursing home services. In an informational submission made following the 2002 IFFC, CVHPA observed that "[t]hese activities strongly suggest that Bon Secours was trying to find a community need that would provide viability for the [Stuart Circle] facility, which was quite difficult given the abundance of health care services in . . . [the area]."

32. As initially approved in December 1999, the present proposed project, *i.e.*, the St. Francis project, would replace and relocate 153-bed Stuart Circle to CenterPointe in Chesterfield County, through construction of SFMC – a 130-bed medical facility. As proposed and then modified during the 1999 review process, SFMC would have 110 medical-surgical beds, 12 obstetric (OB) beds, and eight intensive care unit (ICU) beds, along with six general purpose operating rooms (ORs) and two endoscopy-cystoscopy rooms, a computed tomography (CT) scanner, a magnetic resonance imaging (MRI) scanner, and an emergency department.

33. In a November 1, 2000, letter, BSRHS announced that, effective October 31, 2000, Stuart Circle had "ceased providing patient care services in conjunction with . . . efforts to implement the St. Francis project."

34. The site proposed to host SFMC is within 10 miles of CJW, specifically, 7.2 miles from the Johnston-Willis campus of CJW Medical Center and 8.4 miles from the Chippenham campus of CJW Medical Center.

35. Bon Secours proposes a primary service area that encompasses much of Chesterfield County and parts of Amelia, Powhatan, and Cumberland counties, as well as a portion of Goochland County, lying north of the James River.

36. State Route 288, the western portion of which is currently under construction, will include a bridge spanning the James River west of the City of Richmond and connecting Chesterfield and Goochland counties.[1] Route 288 will enable ready access to SFMC via interstate and interstate-style

[1] According to the Virginia Department of Transportation (VDOT) website, State Route 288 will extend 17.5 miles from State Route 76 to Interstate 64. The entire project, begun in March 1999, is scheduled for completion in the Fall of 2003. Route 288 from the Powhite Parkway Extension in Chesterfield County (Route 76) to I-64 in Goochland County will be a four lane interstate-style highway with 10 interchanges and a bridge over the James River. (The detailed information contained in this footnote is not included in the administrative record regarding the St. Francis project, but is available by viewing the VDOT Internet website, as of January 14, 2003. It is set forth here only for clarification of information already in the record.)

highways from across the greater Richmond area, facilitating the travel of patients and physicians to and from SFMC.

37. Total capital costs associated with the St., Francis project, projected in 2002, are $74,479,700. Eighty percent of this total will be financed through a bond issue, the remaining 20 percent to be funded from accumulated reserves of BSRHS. Total capital costs including interest expense will total approximately $150 million.

38. Based on appropriate evidence and argument presented during the course of the 2002 IFFC and in related written filings, three specific provisions of the SMFP must be set aside. These provisions, *viz*., Subpart (iii) of Subsection B 1 of 12 VAC 5-240-30, Subsection A 2 of 12 VAC 5-240-50, and Subsection C of 12 VAC 5-250-40, are inaccurate, outdated, inadequate or otherwise inapplicable, as discussed in detail below. Subsection A of Section 32.1-102.3 of the Code grants such authority by providing, among other things, that "if the Commissioner finds, upon presentation of appropriate evidence, that the provisions of . . . [the SMFP] are . . . inaccurate, outdated, inadequate or otherwise inapplicable, the Commissioner, consistent with such finding, may issue or approve the issuance of a certificate and shall initiate procedures to make appropriate amendments to such plan."

39. In an informational submission dated October 25, 2002, CVHPA observes that, from 1999 to 2002, 86 percent of all projects proposed for location in HPR IV and authorized by the Commissioner "did not meet one or more of the SMFP standards."

40. As evinced by the general records of the Department and reflected in the administrative record relating to the St. Francis project, since November 2000, several improvements proposed at HCA's CJW Medical Center have received the Commissioner's authorization through issuance of COPNs. These improvements include (i) construction of a five-story cardiac tower, (ii) renovation and expansion of the surgical suite at CJW, (iii) introduction of gamma knife surgery services at CJW, (iv) construction of a neuroscience and outpatient diagnostic center, and (v) construction of a 700-space parking deck. These three projects, currently in progress and scheduled for ultimate completion by January 2004, involve total capital expenditures by HCA exceeding $88 million.

II. DISCUSSION AND ANALYSIS.

A. The Posture of this Administrative Matter.

The judicial review of the Commissioner's December 1999 case decision called for the reopening and continuation of the administrative record regarding the St. Francis project so as to allow a *de novo* decision on the issue of whether the project meets a public need under Virginia law, Section 32.1-102.1 *et seq.* of the Code of Virginia, with both BSRHS and CJW as parties to the administrative proceedings.

In order to give full meaning and appropriate effect to the judicial review, the Commissioner has sought to return the administrative process to an appropriate posture, *i.e.*, to actualize, to the extent possible, the goal of returning the matter to the level of procedural development it had attained just

before November 15, 1999, the date on which the Commissioner denied CJW's petition and effort to show good cause, while allowing the process to benefit from the presentation of additional evidence by the parties.

B. Relation of the Proposed Project to the Twenty Statutory Considerations.

Subsection B of Section 32.1-102.3 of the Code of Virginia requires that, in determining whether a public need for a proposed project has been demonstrated, the Commissioner shall review an application for a COPN in relation to the twenty considerations enumerated in that subsection. The following is an analysis of the St. Francis project in relation to the statutory considerations, made with the benefit of the full record.

The record in this matter, dating back to July 1999 is voluminous and replete with evidence. It contains numerous documents submitted by the parties, as well as comprehensive reports prepared by CVHPA and DCOPN, this Department's professional health planning staff, and many letters and documents submitted by other interested persons. Exclusion from the following discussion of any particular assertion made or piece of evidence presented by either party to this administrative proceeding should not be construed to mean that such assertion or evidence was not reviewed in the process of making the recommendation contained in part III of this document.

1. The recommendation and the reasons therefor of the appropriate regional health planning agency.

The board of directors of CVHPA recommended approval of the proposed relocation of Stuart Circle Hospital to Chesterfield County. CVHPA made its conditional recommendation for approval based on the following reasons, as set forth in an October 8, 1999, letter from its executive director:

> (i) BSRHS' proposal is generally compliant with the applicable standards found in the "General Acute Care Services" (12 VAC 5-240) and "Diagnostic Imaging Services" (12 VAC 5-230) sections of the [SMFP];
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> (ii) BSRHS has demonstrated a facility need to replace the 86 year-old Stuart Circle Hospital off-site;
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> (iii) The relocation of BSRHS resources to Chesterfield County represents a better distribution of health care resources within the region. The proposed service area has a relatively greater current and projected demand for general acute care services and fewer local choices for inpatient care when compared to Stuart Circle's current service area;
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> (iv) The proposed project represents an opportunity to lower health care costs to the region's payors of health care and increase financial access to health care within the proposed service area. BSRHS has historically provided general acute care services at a significantly lower cost to the public and provided relatively more charity care;

> (v) The Capital Area Health Advisory Council, whose members represent the consumers of the entire planning district [PD 15], support[s] the proposed relocation of SCH (as proposed) and recommend[s] the charity care condition which follows.

The Board made its recommendation contingent on BSRHS' agreement to comply with the following conditions, as set forth in the same letter:

> (i) There is no need for additional operating rooms in the planning district; therefore, SFMC will have no more operating rooms than licensed at SCH at the time of closure. If it wishes to increase the number of operating rooms at SFMC, BSRHS will transfer operating rooms from other facilities in Planning District 15 prior to the opening of SFMC, provided that appropriate documentation is supplied in its COPN extension requests to DCOPN and CVHPA;
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> (ii) SFMC must provide care to all patients without regard to an individual's ability to pay. A minimum of 3 % of gross patient revenue must be provided as free services to persons at or below 100 % of the Federal Poverty Level who have no other form of third party health care coverage and/or as free or reduced rate services to persons between 100 % and 200 % of the Federal Poverty Level who have no other form of third party health care coverage. This will include services, performed by the hospital or in collaboration with indigent health care primary care providers and others in the community, provided to residents of both SFMC's service area and SCH's historical primary service area;
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> (iii) SFMC and its partners . . . are required to have an established "front end" procedure for screening patients for eligibility for free or reduced rate services and a sliding fee scale to be used for reduced rate services. SFMC must submit to DCOPN and CVHPA prior to project implementation: a) a copy of the application form and sliding scale to be used, and b) a copy of the procedure to be used in screening patients for financial need. A charity care log must be maintained which documents services provided and certified as accurate by the facility administrator. The charity care log shall include, at a minimum, the date of service, patient's age, ZIP code, city/county, procedure/service type, and the total charges for the services provided, any amount charged to the patient, and any associated physician and medical services fees (if known). The applicant will provide a copy of the charity care log and summary data (total number of procedures/patient days/visits, free or reduced priced charges, and total charges) to the DCOPN and the CVHPA at the end of the fiscal year when the project becomes operational and each fiscal year thereafter;
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> (iv) DCOPN and CVHPA may take any necessary actions to verify the accuracy of information submitted. Noncompliance with these conditions will require a specific plan of correction acceptable to DCOPN and CVHPA. The plan must include ultimate disbursement of all obligated amounts of charity care; and

(v) BSRHS will work with the City of Richmond, the SCH area associations, the Historical Society, and all other appropriate entities to ensure that an acceptable use is found for the SCH buildings in a timely manner. A viable reuse plan for the hospital, parking deck, and Laurel Hill House should be in effect before the transfer of beds to the Chesterfield site.

In December 1999, BSRHS memorialized its agreement to these five conditions, proposed by CVHPA, along with a sixth condition, proposed by Dr. Peterson in a letter dated December 16, 1999, providing that

> BSRHS will redesign and reduce the square footage of its proposed private patient rooms to insure that the rooms are not large enough to meet licensing requirements as semi-private rooms; further, the reduced size of the facility must cause a corresponding reduction in costs that must be reflected in a revised budget and financial pro forma statement that will be submitted to the Division of Certificate of Public Need and the Central Virginia Health Planning Agency for a final reasonableness review prior to issuance of the approval certificate.

2. The relationship of the project to the applicable health plans of the regional health planning agency, the Virginia Health Planning Board and the Board of Health.

The applicable health plan consists of certain portions of the State Medical Facilities Plan (SMFP) found in the several chapters of Title 12 (Agency 5) the Virginia Administrative Code (VAC, 12 VAC 5-320-270 *et seq*.), cited above and set forth below. (Text appearing under this consideration in italics has been selected from the SMFP and precedes discussion of the proposed project in relation to the selected text.)

a. The Guiding Principles of COPN.

The guiding principles of the COPN program are set forth in five enumerated items within 12 VAC 5-230-30, as follows.

12 VAC 5-230-30. Guiding principles of public need. The following general principles will be used in guiding the implementation of the Virginia Medical Care facilities Certificate of Public Need (COPN) program and have served as basis for the development of the review criteria and standards for specific medical care facilities and services contained in this document:

1. The COPN program will give preference to medical facility and service development approaches which can document improvement in the cost-effectiveness of health care delivery. Providers should strive to develop new facilities and equipment and use already available facilities and equipment to deliver needed services at the same or higher levels of quality and effectiveness, as demonstrated in patient outcomes, at lower costs;

2. The COPN program will seek to achieve a balance between appropriate levels of availability and access to medical care facilities and services for all the citizens of Virginia and the need to constrain excess facility and service capacity;

3. The COPN program will seek to achieve economies of scale in development and operation, and optimal quality of care, through establishing limits on the development of specialized medical care facilities and services, on a statewide, regional, or planning district basis;

4. The COPN program will give preference to the development and maintenance of needed services which are accessible to every person who can benefit from the services regardless of ability to pay.

5. The COPN program will promote the elimination of excess facility and service capacity. The COPN program will promote the conversion of excess facility and service capacity to meet identified needs. The COPN program will not facilitate the survival of medical care facilities and services which have [been] rendered superfluous by changes in health care delivery and financing.

Authorization of the St. Francis project would be consistent with the guiding principles underlying the COPN program. CJW argues that the very last sentence of the principles, containing a statement that the COPN program will not facilitate the survival of superfluous medical care facilities, warrants denial of the St. Francis project. BSRHS counters, maintaining that Stuart Circle was

> no more superfluous than any other existing acute care general medical/surgical hospital facility in PD 15. The advanced age of [Stuart Circle's] physical plant did not render it superfluous. HCA [*i.e.*, CJW] would read this guiding principal as encouraging the denial of COPN applications for replacement facilities that have reached the end of their useful lives in any area that harbors an apparent excess of licensed inpatient hospital beds. There is no such mandate in the COPN law. The Commissioner's consistent interpretation of this law recognizes a right of replacement for facilities that demonstrate a need to replace and propose a project that is reasonable in location, scope and cost.

This assertion is an apt synopsis of the approach taken in reviewing past proposals to replace and relocate hospitals. As shown by prior decisions, the COPN program was not designed to force aged facilities out of operation.

These guiding principles, as stated in the prefatory paragraph to 12 VAC 5-230-30, "will be used in guiding *the implementation of* the . . . COPN program and have served as bas[es] for the development of the review criteria and standards of specific medical care facilities and services . . . . [Emphasis added.]" They reflect and continue the original underpinnings of health facilities planning, while allowing the application of more specific standards and provisions, set forth elsewhere in the SMFP and designed to promote these principles.

b. Standards Regarding General Acute Care Services.

Standards and considerations aiding the review of applications proposing general acute care services are set forth in Chapter 240 of the SMFP, *i.e.*, 12 VAC 5-240-10 *et seq*.

12 VAC 5-240-20. Accessibility. Acute care in-patient facility beds should be within 45 minutes average driving time, under normal conditions, of 90 % of the population.

This standard has already been met in PD 15. A small portion of the population that would likely be served by SFMC, consisting of some residents of the counties of Goochland, Cumberland and Buckingham, appear not to benefit from the overall health system's compliance with this standard. Regardless, any conclusion that a proposed project would not provide a significant improvement in geographic access does not constitute a finding of inconsistency with this provision.

12 VAC 5-240-30. Availability. A. Need for new service. [Not applicable.] *B. Off-site replacement of existing services. 1. No proposal to replace acute care in-patient beds off-site, to a location not contiguous to the existing site, should be approved unless: (i) off-site replacement is necessary to correct life safety or building code deficiencies; (ii) the population served by the beds to be moved will have reasonable access to the acute care beds at the new site, or the population served by the facility to be moved will generally have comparable access to neighboring acute care facilities; and (iii) the beds to be replaced experienced an average annual utilization of 85% for general medical/surgical beds and 65 % for intensive care beds in the relevant reporting period.*

Determining the Applicable Regulatory Text. As noted above, the St. Francis project was submitted in July of 1999. In December 1999, the Commissioner issued a COPN which, in its clear effect, authorized the replacement and relocation of SCH, and the related establishment of a new hospital through the construction of SFMC. This project has been reviewed by CVHPA and the Department from its outset as a project proposing the replacement and relocation of a hospital. On November 1, 2000 – while the 1999 COPN stood in effect, BSRHS submitted a written notice to the Department that patient care services at SCH had ceased effective the previous day, October 31, "in conjunction with . . . efforts to implement the project for its planned relocation to . . . SFMC."

On September 26, 2002 – after the Commissioner set aside the COPN earlier that month, CJW raised a contention that, since SCH has been closed since October 2000, the St. Francis project currently constitutes an application seeking approval of the establishment of a new hospital and may no longer be reviewed as a proposal to replace and relocate a hospital. CJW maintains, therefore, that the standards in subsection A of this section of the SMFP should apply, rather than those in subsection B.

Although CJW's appeal of the good cause denial was pending when BSRHS acted to close SCH, the COPN authorizing the replacement and relocation of SCH was fully effective then. BSRHS represents that

> [I]n late 2000, due to rapidly declining utilization, mounting financial losses, mounting pressure from neighbors of the facility to identify an acceptable reuse, and the COPN condition requiring Bon Secours to work with such neighbors, Bon Secours ceased operations at [SCH] and proceeded to ready the facility for sale. [Footnote omitted.] At no time since filing its COPN application has Bon Secours taken any action constituting

> any relinquishment of its rights to continue the mission of the acute care facility known as Stuart Circle through replacement.[2]

CJW contends, however, that "[t]he volume at Stuart Circle Hospital did not drop until Bon Secours' April 2000 announcement that it was closing the hospital."

Regardless of the timing of occurrences and processes in relation to each other, BSRHS effected the closure of Stuart Circle in order to reverse a financial drain brought on by low utilization, perhaps worsened by general awareness of Stuart Circle's planned relocation and replacement. The closure appears to have been effected in furtherance of prudent financial stewardship, in good faith and with reasonable reliance on an existing COPN, duly issued in December.[3] Closure of SCH would likely have been closer in time to the establishment of the new facility but for the appeal maintained by CJW. CJW should not be allowed now to argue that the St. Francis project, which was and continues to be a proposal to replace and relocate a hospital, has somehow become reformulated as a proposal to establish a new hospital.

Absent a compelling public need or policy to the contrary, I do not believe that any provision of the SMFP or the COPN law should be construed so as to require a regulated person to continue operating a facility, when the impending cessation of that facility's operation is fully contemplated by and, indeed, required by the very terms of an effective COPN and a particular provision of the SMFP, and continued operation would be a substantially imprudent business practice, raising the potential of financial harm to the overall health system.

Despite CJW's attempt to interpret present circumstance in a manner to its benefit, I see no reasonable basis upon which to re-characterize the St. Francis project as an application seeking approval of a new hospital. It was and remains a proposal to replace and relocate a hospital, similar to prior projects approved by the Commissioner. Subsection B, rather than Subsection A, of this provision of the SMFP applies to the proposed project, as discussed below.

Reviewing the Proposal in Direct Relation to the Applicable Text of this Section. First Subpart. In relation to the specifics of the first subpart of the applicable section of the SMFP, *i.e.*, Subsection B 1 of 12 VAC 5-240-30, a detailed assessment prepared by ODell Associates, Inc., and dated June 30, 1999, sought to "examine the efficacy of maintaining . . . [SCH] on line as a combination inpatient and outpatient hospital in its current configuration, and upgrading the facilities as necessary to operate as a state-of the-art hospital into the next century." The assessment cataloged numerous life safety, building code violations of the Americans with Disabilities Act of 1990 (ADA), in addition to building system and aesthetic problems leading to operational inefficiencies.

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[2] As noted above, BSRHS submitted two applications for COPNs in 1997 seeking authorization for improvements at Stuart Circle. In an informational submission made following the 2002 IFFC, CVHPA stated that "[t]hese activities strongly suggest that Bon Secours was trying to find a community need that would provide viability for the [Stuart Circle] facility, which was quite difficult given the abundance of health care services in . . . [the area]."

[3] In a written submittal following the 2002 IFFC, BSRHS asserts that HCA attempted to recruit personnel away from SCH before its closure, thereby exacerbating efforts to maintain sustainable and reasonable operations at SCH.

ODell concluded that SCH, the core of which was constructed in 1912, exhibited numerous deficiencies, consisting of structural limitations and instances of physical deterioration, health hazards and failures to comply with various requirements. Expansion of the facility onto contiguous parcels would be impossible, neighboring land interests have historically limited operational flexibility, and correcting the deficiencies would substantially disrupt ongoing health care operations at SCH. ODell estimated that the cost of modernizing SCH and to continue its service effectively would total approximately $35,500,000 – a sum nearly half the current estimated capital cost of constructing SFMC. Further, BSRHS maintains that such a project would fail to bring SCH's structure into full compliance with applicable requirements. The off-site relocation of SCH, as contemplated by the St. Francis project, would correct the deficiencies that prevailed during SCH's operation.

Second Subpart. In relation to the second subpart, persons who were served by SCH have several nearby facilities offering inpatient hospitalization and related health care services from which they may gain reasonable access. In fact, ample hospitalization resources within a five-mile radius of the structure formerly operating as SCH exist.

Third Subpart. The third subpart of this subsection specifies that a proposal to replace acute care inpatient beds off-site should not be approved unless the beds to be replaced have recently experienced an annual utilization level of 85 percent for general medical-surgical beds and 65 percent for intensive care beds, as reported by health care facilities for inclusion in an established, state-wide database. BSRHS asks that this subpart, along with two other provisions of the SMFP be set aside, pursuant to the statutory mechanism allowing the Commissioner to undertake such action.

I believe that the Commissioner should exercise his statutory authority to

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the provision contained in this subpart, pursuant to Subsection A of Section 32.1-102.3 of the Code. BSRHS argues that this standard should be set aside. Appropriate evidence presented and argument made in the course of this proceeding establishes that this provision is "outdated [and] inadequate."

In 1998, the 135 medical-surgical beds operating at SCH experienced a utilization level of 41.2 percent, and its eight intensive care beds experienced a utilization level of 51.6 percent. (Notably, under this standard, no complement of medical-surgical beds operating in the twelve PD 15 hospitals that year would have warranted relocation off-site, and only one – that consisting of the complement of medical-surgical beds at Bon Secours - St. Mary's Hospital, enjoyed a utilization level greater than 60 percent.)

The assumptions and considerations prevalent at the time this subpart was drafted are less compelling in light of prevailing circumstances and understanding, as discussed below. In particular, as more and more patient care is delivered in an outpatient setting, the level of inpatient occupancy – the very index to which this standard looks – becomes less reliable as an indicator of the overall level of medical and business activity experienced by a hospital. Reliance on the customary calculation of bed utilization is outdated and inadequate for the specific purpose of determining whether public need

exists for a proposal to replace and relocate beds off-site. Such a calculation ought not provide a definitive obstacle to the development of resources otherwise warranted and justified in meeting public need.

CJW staunchly maintains that the low utilization levels of SCH's acute care beds, as well as ostensibly low utilization of such beds at CJW and, indeed, at all hospitals in PD 15, along with a general surplus of such beds in PD 15 (estimated by CVHPA in 1999 to total 918 by 2004 and estimated in 2002 by CJW to total 712 by 2007),[4] a high bed to population ratio in PD 15 (3.7 beds per thousand population), and a high bed use rate in PD 15 (600 patient days per thousand population), counsels against approval of the St. Francis project.

Unnecessary duplication of existing health care resources should be avoided, and regulatory mechanisms should seek to limit such duplication where statutory authority allows. But empirical evidence deduced during and after the 2002 IFFC indicates an unclear correlation between utilization levels, as customarily calculated, and costs borne by the health care system. The apparent tenet upon which the law has encouraged maintaining a limit on the number of licensed beds , *i.e.*, that excess beds increase costs, seems unconvincing in this case, as at least two Bon Secours hospitals in PD 15 exhibit low cost per adjusted admission despite relatively low numerical utilization levels. More important, the 2002 IFFC included discussion regarding whether a utilization level of 85 percent is realistic or even desirable for a hospital to attain or maintain.

The 85 percent utilization standard needs to be reexamined in light of current industry practice and public need. Since 1992, the average length of stay for patients in hospitals has decreased, leading to greater turnover of beds, lower numerical occupancy and greater difficulty in maintaining the standard. Increased specialization at some hospitals in PD 15 has led to smaller work units within those facilities, again, leading to lower numerical occupancy. Also, many facilities report that hospital beds are often used for patients staying less than 24 hours; these patients, and hence, this aspect of utilization are often not reflected in the numerical calculation of occupancy.

CVHPA has, since 1999, recommended approval of the St. Francis project, but proposes allowing the bed utilization levels that prevailed at SCH to determine the scope and number of its proposal to relocate beds. As shown above, this appears to be an approach historically taken when reviewing replacement projects. It appears to reflect an effort to tailor this provision of the SMFP into a useful adjunct to the Commissioner's general analysis of replacement and relocation projects, *i.e.*, whether such a proposal is necessary in a facility-specific sense, and whether it is reasonable in scope, location and cost.

Using the utilization levels that SCH maintained in 1998, CVHPA concludes that a hospital of 72 beds, consisting of 65 medical-surgical and seven intensive care beds, would be justified. CVHPA, however, based on its experience, further concludes that such a small hospital would not be feasible,

[4] The very terms and internal structure of 12 VAC 5-240-30 indicates that the methodology for calculating a PD-wide surplus or deficit of acute care beds is relevant when reviewing an application for a new service, and is not applicable in reviewing an application for the off-site replacement of existing services.

"may not meet the demand of the proposed service area into the future . . . ," and later suggests that, if approved, SFMC should have 130 beds, consisting of 110 medical-surgical beds, 12 obstetric beds, and eight intensive care beds. BSRHS asserts that "[a]pplying this subsection of the SMFP rigidly would bind the sizing of a hospital, intended to meet the needs of an area experiencing growing population, to the declining utilization of an aged facility in the overbedded City of Richmond."

The task of determining public need for acute care services should include consideration of the need to respond to public crisis or catastrophe. Without compelling reasons counseling otherwise, a decision that would result in the removal of existing or recently-operational acute care resources from a metropolitan area, through the regulatory preclusion of their replacement, seems unwarranted and imprudent. Preserving resources that may provide critical surge capacity carries significant social benefit and utility.

This provision of the SMFP ought not be a determinative bar to deserving projects that harbor considerable public benefit. The Commissioner should set aside this provision because it is outdated and inadequate.

2. The number of beds to be moved off-site must be taken out of service at the existing facility.

Since first applying for authorization to implement the St. Francis project, BSRHS has made its awareness of this provision known and has clearly stated its intention to comply with it. The COPN, issued on December 29, 1999, and set aside on September 6, 2002, specifies that BSRHS was authorized to establish SFMC, and "[a]s a result[,] the 153-beds and three general purpose and two endoscopy-cystoscopy operating rooms at [SCH] will close and be de-licensed when the new hospital opens."

As noted above, however, SCH ceased operating on October 31, 2000, in apparent contemplation of and reliance upon, the December 1999 approval of the hospital's replacement – a final case decision made by the Commissioner but appealed by CJW. BSRHS represents that continued operations at SCH became unreasonably costly and imprudent, as utilization had dropped, partially in anticipation of SCH's eventual closure, and further, that since no relinquishment of any related license occurred, this closure does not create an obstacle to the eventual planned replacement of SCH by SFMC.

At the 2002 IFFC, CJW sought to portray this closure as reason to consider the St. Francis project as a proposal for a new hospital, rather than a replacement, in part through resort to a fundamentally dissimilar case, and to assert that allowing BSRHS to proceed with a replacement of a closed hospital would, as Dr. Tompkins asserted,

> undermine . . . [an] orderly process [for replacement]. It would basically make the CON process useless to bank resources for some two years, three years, five years, 20 years period later, [and] would introduce great lack of clarity into the health planning process.

This hyperbolic assertion is inaccurate, insofar as any holder of a COPN must apply for renewal it if the project is not completed within one year, and distracts from the underlying purpose of the provision. (Notably, the closure of SCH, along with the unrelated closure of Capitol Medical Center, in the City of Richmond, in 2001 appear to have beneficially affected utilization of HCA - Retreat Hospital, in the City of Richmond, which experienced nearly 60 percent more discharges from 1999 to 2001, according to BSRHS.)

The purpose behind inclusion of this provision in the SMFP is to prevent the continued operation of beds that have been identified for off-site replacement upon the implementation of an approved replacement of those beds. This provision should not be construed to require the continued operation of resources when the replacement of those resources has been authorized (as it had been in 2000 when BSRHS closed SCH) and continued operation would be costly and wasteful to the facility's owner and, potentially, to the health care system, unless a countervailing public need or a legal duty to continue operation exists.

3. The off-site replacement of beds should result in a decrease in the licensed bed capacity of the applicant facility(ies) or substantial cost savings, cost avoidance, consolidation of underutilized facilities, or in other ways improve operation efficiency or improvements in the quality of care delivered over that experienced by the applicant facility(ies).

Similar to other projects approved in recent years for the replacement of hospitals, the approval of SFMC as a replacement of SCH would result in a elimination of 23 acute care beds from the inventory in PD 15, which has a numerical surplus of such beds.

C. Alternative need for the conversion of underutilized licensed bed capacity. [Not applicable.]

D. Computation of the need for general medical/surgical and pediatric beds. [Not applicable.]

E. Computation of need for distinct pediatric units. [Not applicable.]

F. Computation of need for intensive care beds. [Not applicable.]

CJW notes that use of the methodology contained in the latter three subsections, listed directly above, identifies a surplus of existing acute care beds in PD 15 that should bear direct relation to whether the St. Francis project is ultimately approved. A numerical surplus of acute care beds, calculated by use of the methodology contained in these provisions, has existed in PD 15 for several years. In 1999, CVHPA estimated this numerical surplus to total 918 by 2004; in 2002, CJW estimates such a surplus to total 712 by 2007.

Subsections D and F of 12 VAC 5-240-30, are applicable only in reviewing a proposal for new services. The very terms of Subsection D show that it applies when determining "[a] need for *additional* acute care inpatient beds. [Emphasis added.]" Existing law, as applied by the Commissioner in past decisions addressing applications for the replacement of hospitals, and regulations set forth elsewhere in the SMFP are sufficient to gauge the public need for a project proposing the replacement of beds, so that resort to an inapplicable provision, except perhaps for illustration or for clarification of general circumstances, ought not be undertaken.

12VAC5-240-40. Continuity; system coordination for intensive care beds. A. All proposals to establish or expand general intensive care beds or cardiac care beds should provide written policies and agreements providing for transfer of patients to specialized units outside of their facility.

The record indicates that the St. Francis project complies with this provision. The parties have raised no direct issues regarding ability to comply with this provision, and none appear to exist.

B. [Regards proposals to establish or expand intensive care or cardiac services.] [Not applicable.]

12 VAC 5-240-50. Cost. A. Use of underutilized beds. 1. [Not applicable.] *2. No hospital should relocate beds to a new location if underutilized beds (less than 85 % average annual occupancy for medical/surgical and pediatric beds and less than 65 % average annual occupancy for intensive care beds) are available within ten miles of the proposed site of the applicant hospital.*

I believe that the Commissioner should exercise his statutory authority to

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the provision contained in this subpart, pursuant to Subsection A of Section 32.1-102.3 of the Code. BSRHS argues that this standard should be set aside. Appropriate evidence presented and argument made in the course of this proceeding establishes that this provision is "outdated [and] inadequate."

This standard consists of a planning guideline intended to encourage the proposal of relocations that reflect a reasonable and appropriate dispersion of resources. At the 2002 IFFC, BSRHS raised a key issue regarding the ability of the utilization rates of acute care beds to portray, in an accurate manner, a relevant picture of operational reality, and to assist, in a dependable and appropriate way, the determination of whether public need for the St. Francis project exists. In particular, as more and more patient care is delivered in an outpatient setting, the level of inpatient occupancy becomes less reliable as indicator of the overall level of business activity experienced by a hospital.

This provision of the SMFP is outdated and inadequate for the same reasons Subpart (iii) of Subsection B 1 of 12 VAC 5-240-30, discussed above, is outdated and inadequate. The 85 and 65 percent utilization standards need to be reexamined in light of current industry practice and public need. Since 1992, the average length of stay for patients in hospitals has decreased, leading to greater turnover of beds, lower numerical occupancy and greater difficulty in maintaining the standard. Increased specialization at some hospitals in PD 15 has led to smaller work units within those facilities, again, leading to lower numerical occupancy. Also, many facilities report that hospital beds are often used for patients staying less than 24 hours; these patients, and hence, this aspect of utilization are often not reflected in the numerical calculation of occupancy.

The calculation of acute care bed utilization, whether specific to a hospital or general to a planning district, customarily involves using licensed bed capacity as the ultimate denominator. BSRHS maintains that this mechanism leads, in some cases, to deceptively low utilization levels, and that this phenomenon is operative in relation to the utilization of acute care beds at CJW.

This inadequate provision, BSRHS maintains, fails to reflect a reality that not all licensed beds are necessarily available. Some hospitals may decide, in the sound pursuit of reasonable business operations, not to devote staff to maintaining certain licensed beds as operative for a particular length of time. Such beds may require involved or protracted efforts to bring them into operation. This would necessarily delimit the number of licensed beds that can be utilized, thereby, in some cases, truncating the relevance of a hospital's number of licensed beds to the issue of public need for of the relocation of a hospital nearby. As BSRHS observes in a post-IFFC submittal, "[w]hen a patient needs to be admitted and no beds are available, save those which exist only on a hospital's license, devotion to health planning on the basis of licensed occupancy serves no public good and risks public harm."

BSRHS presented evidence to the effect that CJW, through established and unchallenged market power south of the James River, has manipulated circumstances by suppressing its staffing of beds at CJW, leading the number of utilized beds, in relation to its number of licensed beds, to exhibit a resultantly and deceptively low numerical level of utilization at CJW. BSRHS asserts that the utilization level of staffed-*only* beds at CJW exceeds 90 percent.

BSRHS presented a report prepared by PricewaterhouseCoopers, an international accounting and professional services firm, dated September 20, 1999, that observed "[f]or the years 1994 through 1997, . . . [CJW] and Columbia-Richmond hospitals yielded an estimated $163 million and $282 million, respectively, in estimated possible 'free cash flows'." At the 2002 IFFC, Dr. Noether noted that "[o]ne would expect that in a market that was competitive, reasonably competitive, even if not perfectly competitive, that prices received and profits enjoyed by a facility would not be particularly different from benchmarks reflecting other areas of the country that presumably are an average of more or less competitive areas."

As evinced by the general records of the Department and reflected in the administrative record relating to the St. Francis project, since November 2000, several improvements proposed at CJW have received the Commissioner's authorization through issuance of COPNs. These improvements include construction of a five-story cardiac tower, renovation and expansion of the surgical suite at CJW, introduction of gamma knife surgery services at CJW, construction of a neuroscience and outpatient diagnostic center, and construction of a 700-space parking deck. These three projects, currently in progress and scheduled for ultimate completion by January 2004, involve total capital costs exceeding $88 million.

These improvements at CJW will increase its ability to compete in the health care marketplace and to retain its current substantial presence south of the James River. As a general observation, a for-profit corporation might normally refrain from such large expenditures if it believed the prospects of recouping such investment with sizable profits were not likely in the face of encroaching competition. The evidence shows CJW can operate with an appropriately-sized hospital, such as SFMC, located 7.2 miles away.

As discussed above, at the 2002 IFFC, Dr. Anderson, an expert witness presented by CJW stated generally that "the cost of an empty bed is higher in low occupancy hospitals than for higher occupancy rate hospitals." In response at the IFFC, BSRHS asked, essentially, whether the

denominator in such calculations may be reliably determined to represent a hospital's total licensed beds or whether the denominator reflects only a hospital's staffed beds. In a post-IFFC submittal, BSRHS called the reliability of data purporting to demonstrate such a statement into question.

BSRHS also observes that the distance-based standard "has never been applied by the Commissioner to block a relocation of a replacement facility to a site within 10 miles of another hospital." In 1993, the Commissioner approved the relocation of Richmond Memorial Hospital to Hanover County, in PD 15, thereby approving the construction of Memorial Regional Medical Center (MRMC). This approval issued despite the existence then of seven hospitals within approximately ten miles of the site proposed for MRMC. None of the existing seven hospitals then met the occupancy level for medical-surgical and pediatric beds, prescribed by this provision, and only two met the prescribed level for intensive care beds.[5]

Setting aside this provision should not necessarily damage the Commissioner's ability to look critically at where a replacement hospital is proposed to be situated, in relation to existing facilities. In past cases, the Commissioner has undertaken a general analysis of replacement and relocation projects, *i.e.*, whether such proposals are necessary in a facility-specific sense, and whether they are reasonable in scope, location and cost. The inclusion of location in this analysis ought properly be seen as retaining a tool for assessing whether the proximity of a proposed relocation to existing hospitals is reasonable. The Commissioner should set aside this provision because it is outdated and inadequate.

B. Reasonable construction cost. 1. The cost per square foot of new construction as well as renovation to the exiting facility should be consistent with state and regional costs for similar facilities and patient units.

In 1999, CVHPA and DCOPN determined that the construction costs associated with the St. Francis project were reasonable. Based on 1999 estimated direct construction costs, CVHPA stated then that the construction cost per gross square foot "compares very favorably with previous and current relocation proposals," after adjusting for inflation. The currently estimated costs have increased somewhat, due in part to the ensuing delay, but remain reasonable.

2. Preference will be given to those proposals which identify the major source of capital as accumulated reserves.

This provision applies in cases where two or more applicants are competing for authorization of the same or similar projects. CJW has pointed to the intention of BSRHS to fund only 20 percent of the project's capital cost through the allocation of accumulated reserves, and the total capital and financing costs associated of the project, expected to exceed $155,000.000. The remaining 80 percent of the capital cost of the St. Francis project would be financed through a bond issue. This is not an unreasonable structure for financing a large facility-based health care improvement.

[5] PD 15 does not reflect this distance-based standard, as several acute care facilities exist within far fewer than ten miles of others, without apparent adverse financial effect directly tied to such proximity. (Applicability of this standard, of course, exists only when existing beds are close in proximity*, available and underutilized* (as specified in this provision of the SMFP).

C. Operating cost and charges. 1. The applicant should demonstrate that projected operating costs and charge structure will be comparable or less than similar facilities operating in the same planning district.

BSRHS facilities generally have some of the lower costs and charges for acute care services in PD 15 and SFMC should reflect this. BSRHS presented evidence at the 2002 IFFC, constituting its analysis of inpatient hospital expenditures for Virginia state employees' from 2000 and 2001. This analysis indicates an average cost per adjusted case at HCA facilities that was 29.6 percent greater than the same average cost at BSRHS facilities.

CJW contends that the efficiencies and decreased operating costs projected by BSRHS depend on unrealistic utilization expectations and are not likely to be realized, and would reduce occupancy at existing hospitals in PD 15, thereby increasing their costs. At the 2002 IFFC, even CJW's expert witness, Dr. Anderson, noted that in the health care arena generally, neither a monopoly nor perfect competition exists, and "you essentially don't have very good predictive models as to what will happen to the price and what will happen to the cost in those situations." Dr. Anderson referred to the prevalence of "game theory" in present attempts to understand economic and human behavior.[6] He suggested that whether the introduction of competition in PD 15 south of the James River would lower costs and charges depends on a complex interplay of issues, decisions and reactions, and is ultimately unpredictable.

Generally, theory imparts few certitudes. I find no reason indicating that SFMC would not continue the practice of having comparably lower costs and charges, and I believe that substantial evidence exists indicating that the competition SFMC would introduce would have a generally beneficial effect on health care costs and quality in PD 15, despite Dr. Anderson's admonishment against confident prediction.

In an August 5, 1999, letter to the Commissioner supporting the St. Francis project, Trigon Services, Inc., stated that "[c]urrent hospital charges [in PD 15] south of the [James R]iver do reflect what we normally see in a non-competitive environment." Further, Trigon stated that, if the St. Francis project were approved, it "anticipate[s] the cost to consumers will follow the historic charges associated with St. Mary's [Hospital] and . . . [Memorial] Regional Medical Center," two hospitals owned and operated by BSRHS. According to Trigon, charges at BSRHS' facilities "run approximately 25% less per case or 13% less per day . . . than those currently available [south of the river]." On September 19, 2002, Trigon wrote to reaffirm its support for the St. Francis project, noting

[6] Avinash Dixit, professor of economics at Princeton University, explains that "game theory," which has an impact on situations encountered daily, ". . . studies interactive decision-making, where the outcome for each participant or 'player' depends on the actions of all. If you are a player in such a game, when choosing your course of action or 'strategy' you must take into account the choices of others. But in thinking about their choices, you must recognize that they are thinking about yours, and in turn trying to take into account your thinking about their thinking and so on. . . . This science is unusual in the breadth of its potential applications. . . . [T]he precepts of game theory are useful in a whole range of activities, from everyday social interaction and sports to business and economics. . . ." (The information contained in this footnote is not included in the administrative record regarding the St. Francis project, but is available by viewing the PBS Internet website at http://www.pbs.org/wgbh/amex/nash/sfeature/sf_dixit.html, as of January 15, 2003. It is set forth here only for clarification of information already in the record.)

that "[a]lthough a number of years have passed . . . Trigon remains convinced that a new facility in the western Chesterfield region would serve to increase competition and lower medical costs."

On September 26, 2002, Aetna, Inc., another large national health insurance provider, wrote the Commissioner, expressing "an obligation to [its] members, plan sponsors and participating hospitals and physicians to comment on any marketplace developments that may affect price, quality or availability of health care services. . . . [T]he primary reason for this relocation and replacement is to ensure increased access to quality health care services in the Chesterfield, Virginia area." Further, the letter stated Aetna's assessment that the St. Francis project would "positively impact the price, quality and access to health care in Chesterfield and the greater Richmond area."

CJW asserts that the views of insurance companies should be discounted because CJW sees them as having taken "inconsistent positions over time." On the first day of the 2002 IFFC, however, Dr. Anderson, a nationally-recognized professor and author specializing in the area of health care finance and policy called by CJW as an expert witness, testified that payments made by private insurers is what "you have got to pay attention to" in gauging the financial effect of a proposed project.

As a post-IFFC submission, CJW submitted an October 17, 2003, letter in which CIGNA HealthCare stated that it "does not believe that the approval of [the St. Francis project] will necessarily lower CIGNA's payments to Richmond area hospitals."

Notably, the COPN law affords certain "third-party payors" the status of being parties to the administrative proceedings regarding an application for a COPN (including the IFFC), if they choose to participate. The views of insurers, and their role as reflected in statute, are of considerable importance in determining and anticipating effects on general costs. Two of these views complement the evidence pointing to the benefits of competition that the proposed project poses.

2. For projects involving an off-site replacement of beds, the applicant should, in addition to the above standard, demonstrate that the operating costs and charge structure of the proposed facility shall be comparable to, or less than continued operations at the existing facility.

SCH, originally built in 1912 with additions made in 1919, 1954, 1957, and 1978, occupied one of the oldest hospital facilities in the Commonwealth and was the longest continuing-use facility in PD 15 when it closed in late 2000. The building suffered from numerous deficiencies and, as detailed in the 1999 report prepared by ODell, was marginally viable in terms of plant efficiency and provision of services. SCH's design was based on an inpatient model of care. Its ability to provide outpatient care was limited, and its age presented numerous challenges that would be incompletely addressed by a $35 million renovation. BSRHS anticipates the construction of St. Francis Medical Center to generate savings and to effect efficiencies due to its design coming amidst contemporary medical practice and the latest understanding of how best to devise modern facility operations.

3. Preference should be given to those facilities which have consistently demonstrated the highest levels of charity care as a percent of total patient revenues as reported to the Virginia Health Services Cost Review Council. [NOTE: The Virginia Health Services Cost Review Council no longer exists; many of its programmatic activities have been transferred to the Department of Health, which discharges this particular activity in collaboration with Virginia Health Information.]

Data showing an applicant's willingness to provide charity and indigent care, the amount of that care and the degree to which the applicant has consistently made such a contribution are issues squarely relevant to a determination of public need. This subdivision exists, however, to allow the awarding of a preference to a deserving applicant when it is competing with other applicants for authorization of resources. The matter of charity care is addressed in relation to the fifth statutory consideration, below.

12 VAC 5-240-60. Quality; accreditation and compliance with chapters. A. The applicant should provide assurances that the proposed facility or units will be designed, staffed, and operated in compliance with applicable state licensure chapters.

Bon Secours represents that, "the proposed replacement facility will be designed, staffed and operated in compliance with Virginia's laws and regulations pertaining to hospital licensure."

B. The applicant should agree to apply for accreditation with the Joint Commission on Accreditation of Healthcare Organizations [JCAHO] *or other appropriate accreditation organization.*

Bon Secours represents that SFMC would be "designed, staffed and operated in compliance with Virginia's laws and regulations pertaining to hospital licensure . . . and would apply for JCAHO accreditation."

c. Standards Regarding Obstetrical Services.

Standards and considerations aiding the review of applications proposing obstetrical services are set forth in Part II of Chapter 250 of the SMFP, *i.e.*, 12 VAC 5-250-20 *et seq*. For at least several years before its closure, SCH did not provide obstetrical (OB) services. BSRHS proposes the establishment of a 12-bed OB unit at SFMC.

12 VAC 5-250-20. Acceptability; patient education. Obstetrical service providers should offer an array of family planning and related maternal and child health education programs that are readily accessible to current and prospective patients.

OB services at existing facilities owned and operated by BSRHS, including St. Mary's Hospital, exhibit accessibility to the educational programs described. BSRHS represents that OB services at SFMC would also include such programs.

12 VAC 5-250-30. Accessibility; travel time; financial considerations. A. Consistent with minimum size and use standards delineated below, basic obstetrical services should be available within one hour average travel time of 95 % of the population in rural areas and within 30 minutes average travel time in urban and suburban areas.

Most people residing in PD 15 are within 45 minutes' driving time of a hospital and all urban areas of PD 15 are within a 30 minutes' driving time of a hospital. CJW contends that it is "easily within a one hour drive of the rural portions of BSRHS' proposed service area. Currently, PD 15 complies with this goal of the SMFP.

B. Obstetrical and related services should be open to all without regard to ability to pay or payment source.

BSRHS maintains that OB services, if approved at SFMC, would be offered "to all persons without regard to ability to pay or payment source, consistent with the mission and experience of [BSRHS]."

12 VAC 5-250-40. Availability; service capacity; occupancy; consolidation of services. A. Obstetrical services should be located and sized to ensure that there is 95 % probability of there being an empty obstetrics bed in the planning district at any given time.

CJW notes that, as calculated in 1999 using 1996, 1997 and 1998 data, a surplus of 62 OB beds will exist in PD 15 in 2004. BSRHS pointed out at the 2002 IFFC that this standard implies a "single cue" for obstetric services, as if an expecting woman "went from hospital to hospital to find a bed," and suggested that the standard ought to be applied on a facility-specific basis rather than to an entire planning district. Regardless, any conclusion that SFMC would not provide a significant improvement in geographic access, or that such an improvement is not necessary, would not constitute a finding of inconsistency with this provision.

B. Proposals to establish new obstetrical services or expand existing obstetrical services in rural areas should demonstrate that they will perform a minimum of 1,000 deliveries by the second year of operation or expansion and that obstetrical patient volumes of existing providers will not be negatively affected. C. Proposals to establish new obstetrical services or expand existing obstetrical services in urban and suburban areas should demonstrate that they will perform a minimum of 3,000 deliveries annually by the second year of operation or expansion and that obstetrical program volumes of existing providers will not be negatively affected.

I believe that the Commissioner should exercise his statutory authority to

SET ASIDE

the provision contained in Subsection C of this section, pursuant to the specific authority granted him by Subsection A of Section 32.1-102.3 of the Code. BSRHS argues that this standard should be set aside. Appropriate evidence presented and argument made in the course of this administrative proceeding establishes that this provision is "inaccurate [and] inadequate."

BSRHS presented statistics at the 2002 IFFC, based on reported empirical data, to show that only six hospitals offering OB services in Virginia performed more than 3,000 deliveries annually in 1999, 2000 and 2001. These six include CJW and Henrico Doctors Hospital – a sister facility to CJW located in PD 15 north of the James River. During these years, at least 65 Virginia hospitals provided OB services. According to evidence presented by BSRHS, during these years, at least 36 of these hospitals performed 999 or fewer deliveries in Virginia, and at least 47 hospitals performed fewer than 2000 deliveries. In short, Virginia's hospitals achieve an average of fewer than 1,400 deliveries annually, and 90 percent of Virginia's hospitals are performing fewer than 3,000 deliveries annually. Presumably, the utilization of OB services at many and perhaps most of these hospitals is sufficient to sustain the proficiency and financial viability of the services.

BSRHS argues that the 3,000-birth standard, coupled with the requirement that a new OB service not result in a negative effect on existing providers of OB services, ". . . acts to block any proposed OB service." BSRHS calculates that generating 3,000 incremental births in a service area, and thereby avoiding harm to an existing provider's utilization, "would require [an] incremental growth in female population of childbearing age of approximately 50,000. Assuming this population cohort makes up 21 percent of total population means that population growth of approximately 238,000 people would be required . . ." in order to justify an expanded or new OB service in a projected service area of Virginia.

CJW observes that the projected annual number of OB discharges from SFMC of 1,366 would be less than half the 3,000-delivery standard through 2010, as projected by BSRHS, and predicts that a reduction in the number of deliveries at CJW, which has one of the six busiest OB services in Virginia, ". . . is almost certain. . . ."

BSRHS argues that, once a hospital reaches a certain level of activity and proficiency, additional increases in utilization do not necessarily enhance quality, and that the entry of a new hospital in PD 15 south of the James River would enhance quality by stimulating competition. Further, BSRHS states that the fixed costs associated with constructing a facility and establishing certain services do not determine prices as much as variable costs, and in view of the support of Trigon and Aetna for the St. Francis project, according to Dr. Noether, "the stronger effect at least viewed by the local purchasers is the beneficial effect [St. Francis] will have in reducing prices by causing greater competition, greatest negotiation, and greater market discipline."

BSRHS also argues that "[t]he failure to include obstetrical services at [SFMC] would deprive the growing suburban service area of a vital service, and would undermine [SFMC's] ability to create the substantial savings . . . [BSRHS anticipates] because it would preserve to HCA a subarea monopoly on a critical service line." As discussed in relation to the fourth, twelfth and twentieth statutory considerations, the omission of OB services at SFMC would also preclude an important aspect of a family residency program centered in Blackstone, which requires its residents to attend 40 OB deliveries.

Further, BSRHS observes that HCA, with an annual total of 8,221 OB discharges in a recent one-year period, had a 57.1 percent market share in PD 15, with BSRHS having a total of 3,442, and a 23.9 percent market share, and the Virginia Commonwealth University Health System (VCUHS), formerly the Medical College of Virginia Hospitals, having 2,735 discharges and a 19 percent share.

Dr. Noether, called by BSRHS to testify at the 2002 IFFC, related the findings of an analysis she conducted, looking at PD 15. She applied a methodology known as the Herfindahl-Hirshman Index (HHI), generally recognized as a revealing means of assessing a general market structure and indicating whether a market is distinguished by a generally competitive nature, or by concentration of market power.[7] By way of background, as she explained, if an infinite number of competing providers

[7] According the U.S. Department of Justice (DOJ), the Herfindahl-Hirschman Index (HHI) is a commonly accepted measure of "market concentration," and is used to discern the level of competition a particular market enjoys. It is

exist in a market, the HHI would be or approach zero. If a market consists of only one provider, market is completely concentrated and the HHI equals 10,000.

According to Dr. Noether, federal regulatory agencies that play roles in promoting and enforcing the federal antitrust laws, including the Federal Trade Commission, deem any market with an HHI that exceeds 1,800 as "concentrated." In PD 15, the HHI for obstetric services exceeds 4,000 (and 3,500 for general acute care services). In that portion of PD 15 located south of the James River, an HHI of 10,000 prevails (when analyzing the market solely in terms of hospital-based share), reflecting CJW as the only provider. South of the river, according to Dr. Noether, "since HCA [*i.e.*, CJW] is the only player, it's a monopoly market, [and]obviously as concentrated as it can get." There are two sub-markets in PD 15, as related by this witness, who observed that she does not "believe that the behavior of consumers and the prices and profits that HCA is enjoying are consistent with the notion that hospitals north of the river are constraining that behavior of the hospital south of the river."

BSRHS presented evidence resulting from its review of the law of five other southern states, indicating that Virginia's standards for the entry of an OB service are comparatively the most stringent; an observation that can only be persuasive and cannot be determinative to a review of proposed OB services in Virginia. BSRHS argues further that "appropriate evidence" exists for the Commissioner to set aside this standard as "inaccurate, outdated, inadequate, or otherwise inapplicable," as authorized by Subsection A of Section 32.1-102.3 of the Code of Virginia.

In a submittal following the 2002 IFFC, BSRHS contends that

> [t]here is appropriate evidence in the record to support a finding that the SMFP standards applicable to the establishment of a new OB service are inadequate and should not serve to block the establishment of such service at St. Francis. No evidence exists in the record supporting 3,000 deliveries as an appropriate minimum utilization level for OB services. The practical effect of such standard would be to bar the development of virtually any new OB service in the Commonwealth. As such, the standard is inadequate to meet the needs of women of childbearing age. Importantly no other state appears to have a COPN utilization standard for OB that even approaches the level contemplated by the SMFP. To the extent approval of the replacement and

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calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. For example, for a market consisting of four firms with shares of thirty, thirty, twenty and twenty percent, the HHI is 2600 ($30^2 + 30^2 + 20^2 + 20^2 = 2600$). The HHI takes into account the relative size and distribution of the firms in a market and approaches zero when a market consists of a large number of firms of relatively equal size. Markets in which the HHI is between 1000 and 1800 points are considered to be moderately concentrated, and those in which the HHI is in excess of 1800 points are considered to be concentrated. Transactions that increase the HHI by more than 100 points, such as certain mergers, in concentrated markets presumptively raise antitrust concerns under the Horizontal Merger Guidelines issued by the DOJ and the Federal Trade Commission. (The information contained in this footnote is not included in the administrative record regarding the St. Francis project, but is available by viewing the DOJ Internet website at http://www.usdoj.gov/atr/public/testimony/hhi.htm, as of January 9, 2003. It is set forth here only for clarification of information already in the record and for the illustration it provides.)

relocation of Stuart Circle would be regarded as inconsistent with 12 VAC 5-250-40, such provision should be set aside as inaccurate, inadequate and outdated.

In light of all the circumstances discussed above, including the apparent need for competition in the OB marketplace in PD 15 south of the James River, the absence of fairness that would attend the enforcement of a generally unattainable standard, and the benefits that accrue from enhancing the ability of a growing number of residents to choose a health care provider and providing a venue for resident training in OB services, the Commissioner should set aside this provision of the SMFP as inaccurate and inadequate.

D. Average annual occupancy of licensed obstetric beds in a planning district should be at the highest attainable level consistent with the above service capacity standard.

Utilization data prepared by CVHPA indicate that the OB beds at CJW were among the most highly occupied in PD 15 in 1998, attaining a utilization level of 69 percent, while the average for all OB beds at PD 15 hospitals was 58 percent. CJW observes that this occurred despite a 22 percent reduction in the total number of OB beds from 1997 to 1998, and asserts that the average annual occupancy of OB beds in PD 15 dropped to less than 49 percent in 2001.

In preparing its recommendation to the Commissioner, CVHPA rejected the position of its staff by recommending that SFMC include OB services. The inclusion of OB services is appropriate in light of the need for such services in the area, as discussed elsewhere in this document.

12 VAC 5-250-50. Continuity. A. Regional Perinatal Center affiliation. Facilities seeking to expand existing obstetrical services should affiliate and coordinate their service program with the Regional Perinatal Center. B. Transfer agreements for high-risk patients. 1. Obstetrical services providers should maintain written transfer agreements with a regional perinatal center specifying the circumstances and procedures under which high-risk maternal patients and newborn infants will be transported to the regional perinatal center and returned to the referring hospital. 2. Written plans and protocols should demonstrate that more than 95 % of extremely low birth-weight infants (less than 1,500 grams) and more than 80 % of low birth-weight infants (less than 2,000 grams) will be delivered at the regional perinatal center.

BSRHS states that, if the St. Francis project receives authorization, it would establish, maintain and coordinate appropriate affiliations, agreements and plans to achieve compliance with these provisions.

12 VAC 5-250-60. Cost. A. The total cost of providing necessary obstetrical services to a community is a function of the number, size, location and relative efficiency of the programs providing care. Preference will be given to proposals which reduce or minimize the aggregate costs of providing obstetrical services to a community. B. Obstetrical unit costs (cost per delivery or per patient day of care) tend to be a function of program size and efficiency. Preference will be given to proposals which demonstrate the ability to provide care at a unit cost below the median and mean unit cost in their perinatal service area.

These provisions provide the creation of a preference, to be awarded a deserving project proposing OB services when such a project is reviewed in competition with other proposed projects. It is inapplicable to the St. Francis project.

12 VAC 5-250-70. Quality standards; data collection. A. [Not applicable.] *B. Proposals to expand existing services or to add new obstetrical services must demonstrate that they will provide infant and maternal mortality and morbidity data, and program and unit cost and charge data, as requested by the Department of Health.*

BSRHS states that it would provide the referenced data and information, as it does already in relation to its OB services at St. Mary's Hospital and MRMC.

d. Standards Relating to Surgical Services.

The St. Francis project entails the relocation and replacement of various health care resources, including surgical resources. Part II of Chapter 270 of the SMFP, found at 12 VAC 5-270-10 *et seq*., sets forth various planning considerations relating to general surgical services.

Insofar as BSRHS agreed before issuance of the 1999 COPN, set aside in September 2002, that PD 15 has no need for additional operating rooms and agreed to a limitation that would prevent the proposed completion of the St. Francis project from resulting in any new or additional surgical capacity in PD 15, the overwhelming majority of provisions in the SMFP relating to general surgical services are inapplicable to this project.

By letter dated December 29, 1999, BSRHS specifically agreed to the first condition attached to issuance of the 1999 COPN, providing essentially, that if BSRHS "wishes to increase the number of operating rooms at [SFMC] beyond those to be transferred from [SCH], [BSRHS] must close and transfer operating rooms from other facilities in [PD] 15 prior to the opening of [SFMC]." In that letter, BSRHS stated clearly that "the operating rooms proposed for [SFMC] shall include the three operating rooms and two endoscopy rooms currently authorized for service at [SCH]. The three other operating rooms proposed for [SFMC] shall be established only through the relocation of operating rooms owned by facilities associated with [BSRHS]" through a specific designation and notification process. The St. Francis project, as it is currently under review, would not add surgical capacity.

CJW's submittals presume, without overt discussion, the applicability of nearly all SMFP provisions ostensibly applicable to the review of surgical services, and offer various conclusions seeking to show inconsistency with the SMFP. I do not find this approach useful or appropriate.

Reflecting the clear facts, the St. Francis project presents only the relocation of the surgical resources, operational at SCH through October 2000, from SCH to SFMC. Accordingly, only one provision of Part II of Chapter 270 of SMFP, specifically Subsection B of 12 VAC 5-270-40 which sets forth considerations useful in reviewing a relocation of surgical resources, potentially applies to the project.

12 VAC 5-270-40. Availability; need. A. Need. [Not applicable.] *B. Relocation. Projects involving the relocation of existing operating rooms within a planning district may be authorized when it can be reasonably documented that such relocation will: (i) improve the distribution of surgical services within a planning district; or (ii) result in the provision of the same surgical services at a lower cost to surgical patients in the planning district; or (iii) optimize the number of operations in the planning district which are performed on an ambulatory basis.*

BSRHS argues that this provision would be inappropriately applied to the St. Francis project. BSRHS asserts that this provision

> contemplates the relocation of operating rooms from one facility to another and is not intended to address separately the relocation of operating room capacity that is bound up with the proposed replacement of an entire hospital facility.

The entirety and breadth of the COPN law, particularly the twenty statutory considerations and the applicable provisions of the SMFP, provide a structure that is sufficient, adequate and appropriate to review the St. Francis project, without the need for a pinpoint resort to an isolated provision, ostensibly applicable but better suited to assist the review of a project that encompasses only the relocation of surgical resources.

Even if this standard were construed as applicable to the St. Francis project, one of the alternative means of showing consistency with the SMFP involves whether the project would "improve the distribution of surgical services within a planning district." The record indicates that the relocation of the operating rooms formerly active at SCH, which had several competing facilities nearby, to the site planned for SFMC, an area exhibiting substantial growth, would markedly improve the distribution of surgical services within PD 15.

e. Standards Regarding Diagnostic Imaging Services.

The St. Francis project entails the relocation and replacement of various health care resources, including equipment and services providing computed tomography (CT) and magnetic resonance imaging (MRI). Parts II and III of Chapter 320 of the SMFP, found at 12 VAC 5-320-20 *et seq*., sets forth various planning considerations relating to these services.

BSRHS maintains that the application of the provisions contained in these two parts of the SMFP to the proposed project is inappropriate. CJW also notes that the standards relating to CT and MRI services "are largely irrelevant to the Bon Secours' overall project." This project does not propose the addition of CT services or of MRI services. It proposes the replacement and relocation of an existing acute care facility that recently offered those services. BSRHS observes that

> [a]s has been the case with other replacement projects, the diagnostic imaging modalities that are utilized by the facility that is the candidate for replacement are subsumed within the replacement project itself and are not required to demonstrate consistency with these separate standards. The COPN law does not authorize the stripping away of a replacement hospital's diagnostic imaging or other service assets in this fashion.

The SMFP provisions against which applications for new or expanded diagnostic imaging are inapplicable to the proposed relocation of such services associated with the St. Francis project.

3. The relationship of the project to the long-range development plan, if any, of the person applying for a certificate.

BSRHS states that "[t]he replacement of [SCH] in western Chesterfield . . . represents a significant endeavor toward achieving the overall vision to deliver the highest quality care, compassionately, efficiently, and at a reasonable price for the population of Central Virginia." The St. Francis project is consistent with BSRHS' long range plan, perhaps expressed earliest in a 1984 planning document, in which St. Mary's Hospital articulated a "strategy" of "[t]arget[ing] growth for current services to the needs of a changing population." This strategy involved an effort at

> recapturing market share for ambulatory care and inpatient referrals from the lucrative areas from Bon Air through Midlothian and Brandermill. Targeting market growth in these areas will imply hospital commitment to . . . increased competition with current providers on the southside and . . . new facility construction in this area of the southside.

CJW underscores this statement and portrays BSRHS's intention as exhibiting a long-standing, aggressive, desire to encroach into geographic areas already adequately served by a market consisting of existing facilities.

Like the system of facilities owned by HCA, the system of Bon Secours facilities provides invaluable health care services to communities in PD 15. As an organization, albeit a non-profit one, Bon Secours must look to the future, and plan and identify articulable programmatic means to remain effective in this endeavor. With a assemblage of several providers of health care serving PD 15, the process of strategic planning must necessarily involve some degree of assertiveness in the health care marketplace, leading ideally to beneficial competition.

4. The need that the population served or to be served by the project has for the project, including, but not limited to, the needs of rural populations in areas having distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

According to the 2000 U.S. Census, Virginia's PD 15 had in that year a total population of 865,941. Chesterfield County, which would host SFMC, is the fourth most populous county in Virginia, with a total population of 259,903 in 2000, showing a 24 percent increase since 1990. Powhatan and Amelia counties to the west and south, while having 2000 populations of 22,377 and 11,400 respectively, exhibited growth rates of 46 and 29 percent respectively over the same decade. Chesterfield County is projected to experience a population growth of between 57,101 and 60,897 from 2000 to 2010, exceeding its total growth from 1990 to 2000, which totaled 50,629. Many of the county's new residents are expected to live in areas in which SFMC would be easily accessible.

In light of the significant potential of the St. Francis project to enhance availability of services to many residents of rural areas, including Powhatan and Amelia counties, the project may be seen as the type of application to be afforded careful attention under this consideration, as amended in the wisdom of the General Assembly. In a letter dated September 23, 2002, the boards of supervisors for

Powhatan and Amelia counties communicated their support for the location of SFMC in their proximity.

The St. Francis project stands to benefit the Blackstone Family Practice residency program, affiliated with BSRHS and located to serve a rural area. According to a family practitioner who also serves as the director of this residency program, called as a witness for BSRHS, in 30 years, it has graduated 160 family physicians, two-thirds of whom later practice in rural areas. The program director believes that SFMC would be a "facility in which we can consolidate current rotations," strengthen OB services in Blackstone, surrounding Nottoway County and other portions of this section of rural Virginia, help to supply primary care physicians for such rural areas and improve access to acute care services for the rural communities this residency program serves.

At the 2002 IFFC, BSRHS presented the testimony of Dr. Noether as an expert witness with specialized knowledge and experience in industrial organization and issues related to competition in health care markets. Dr. Noether related her belief that "many patients [who live south of the James River] do not feel that hospitals north of the river are good substitutes for hospitals south of the river because of the inconvenience associated with the increased travel time if you live south of the river." Two subparts to the market appear to exist, and authorization of the St. Francis project would address this reality by increasing geographic accessibility to acute care services.

5. The extent to which the project will be accessible to all residents of the area proposed to be served.

The proposed location for St. Francis would enhance geographic access for residents of the identified primary and secondary service areas. SFMC would be located near the interchange of two major roadways in the area, routes 288 and 76, and would provide easy accessibility via Route 360 and Route 60. Upon completion of Route 288 and completion of another highway, the Chippenham Connector, in eastern Chesterfield County, the metropolitan area will be served by a system of high-speed roadways that will come close to approximating a *de facto* perimeter highway, although not a true beltway. This system stands to benefit the greater Richmond area and to facilitate travel through and around the area, as seen in other metropolitan areas across the U.S.

CJW contends that BSRHS has omitted portions of Chesterfield County from the predicted service area for SFMC and has constructed a service area that is "gerrymandered." The evidence on this point is complex and mixed. Determining a pattern showing the residential origin of patients discharged from a hospital not yet existent is a difficult endeavor involving analysis, judgment and prescience. Regardless of whether predictions of consumer decision-making turn out to be accurate, substantial evidence exists to suggest that SFMC would serve a geographic area hosting a sufficient and growing population without detracting from the ability of CJW also to serve a reasonable area.

CJW has proven to be a highly profitable facility that is responsive to the service needs of its surrounding community. It is located in direct proximity to major transportation routes, and is undergoing major physical improvements and service enhancements. Despite possible flaws in determining the

service area of SFMC, CJW stands able to weather market challenges and to respond positively to the competition SFMC promises, and to benefit from the population growth occurring in Chesterfield County.

BSRHS, based on its comparatively higher levels of charity care than the existing hospitals in PD 15 south of the James River and its non-profit status, would likely operate St. Francis in a similar manner, providing economic access regardless of patients' ability to pay for services.

Using revenue data provided by Virginia Healthcare Information (VHI), charity care provided by Virginia hospitals can be calculated, as a percentage of gross patient service revenue net of receipts from or payments to the Virginia Indigent Care Trust Fund. Charity care services are those provided to indigent patients for free or at reduced rates. Indigent patients are those whose household incomes are at or below 100 percent of the poverty level as defined by the federal government.

BSRHS provided a level of charity care equivalent to 0.8 percent of its gross patient service revenue in 1997. CJW provided a level of charity care equivalent to 0.5 percent of its gross patient service revenue – reflecting the level provided by the HCA hospital system. The median level of charity care provided by all hospitals in HPR IV, as a percentage of gross patient service revenue, was 0.9 percent in 1997.

Charity Care Provided by the Bon Secours and HCA Acute Care Hospital Systems, 1997

Hospital System	Total Gross Patient Revenues	Total Charity Care Provided	Charity Care as a Percentage of Gross Patient Revenues
BSRHS	$ 535,702,778	$ 4,294,308	0.8
HCA	1,341,225,478	6,046,527	0.5
		*HPR IV Median**	*0.9*

*Reflects charity care provided by 17 acute care facilities in all of HPR IV in 1997, including a total of eight facilities operated by the three hospital systems.

6. The area, population, topography, highway facilities and availability of the services to be provided by the project in the particular part of the health service area in which the project is proposed, in particular, the distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

The particular part of the health service area in which BSRHS proposes to locate the replacement acute care facility contains no acute care hospitals, despite the rank of Chesterfield County as the fourth largest county and the sixth fastest growing county in Virginia. Amelia and Powhatan counties, with a combined population of 33,777, enjoy no acute care facility within their borders. No hospital exists along the nearly-completed arc defined by Route 288, a highway that would assist in defying the dividing effect of the James River, which contributes to the existence of two geographically-distinct areas of behavior within a larger health care and general economic market.

The St. Francis project would bring a second acute care hospital to Chesterfield County, one of Virginia's most populous and rapidly growing counties.

The proposed primary service area had 172,931 residents living in it as of 2000. The record reflects strong bases for arriving at a sound projection of considerable future growth in Chesterfield County. BSRHS asserts that growth in the primary service area's population to the year 2010 is expected to be at the rate of 22.6 percent, such that the 2010 population is expected to reach 212,047 – which would exceed substantially the entire current population of the City of Richmond.

Total population within Chesterfield County is expected to reach 317,004 by 2010 and the fastest growing age cohort consists of those persons aged 50 and over. This cohort grew at a rate of 73.3 percent in Chesterfield County from 1990 to 2000 and is expected to grow 51 percent from 2000 to 2010. Additionally, BSRHS observes that, from 1990 to 2000, the number of foreign-born residents of Chesterfield County doubled to over five percent of the county's population, with the Hispanic population increasing 203 percent and the Asian population increasing 68 percent during this decade.

7. Less costly or more effective alternate methods of reasonably meeting identified health service needs.

In 1999, CVHPA identified three alternatives to SFMC: (i) continue operations at SCH; (ii) replace and relocate SCH, as contemplated by the proposed project; and (iii) continue operating SCH and eventually close it. As discussed above, BSRHS estimates, based on a detailed report, that renovation of SCH would have cost $35.5 million, without meeting certain recently-enacted federal and state requirements. Since SCH was closed in 2000, the only alternative remaining from those identified in 1999 consists of implementation of the proposed project, at a currently-estimated capital cost of $74.5 million.

An additional alternative noted consists of spending over $38,000,000 to augment BSRHS's St. Mary's Hospital in an attempt to enable it to absorb the closure of SCH. Unlike the St. Francis project, construction at St. Mary's would underscore the concentration of acute care services in the urban and suburban areas of PD 15 north of the James River and would not offer the opportunity to introduce beneficial competition in the submarket area south of the James, or to yield the resultant savings to the public.

CJW asserts plainly that the "best alternative, which is obviously the least costly and most effective, is to deny Bon Secours' application."

In 2002, BSRHS identified the "health service needs" at issue to be "the need for [SCH] to be replaced and the need of the growing population in western Chesterfield, Amelia and Powhatan counties to have improved access (both geographic and economic) to a beneficial choice among acute care hospitals. . . . There is no less costly way to improve such access than by replacing [SCH] in the optimal location selected for St. Francis."

BSRHS asserts that, in 1997, CJW had a case mix-adjusted net revenue per discharge of $6,693 and predicts that a comparable figure for St. Francis will be $5,132. Assuming the accuracy of these figures, and, for the sake of illustration, assuming that SFMC would have 4,700 discharges annually and that these discharges would otherwise occur at CJW, the approval of the St. Francis project would result in savings to the health care system exceeding $7.3 million.

The record indicates that allowing BSRHS to establish a presence in the submarket area of PD 15 south of the James River will impart benefits, including greater geographic and economic access to acute care services, and thereby meet identified health service needs and generate savings through the introduction of beneficial competition. Denial of the St. Francis project would disserve these needs. No less costly or more effective methods of reasonably meeting these needs have been presented.

8. The immediate and long-term financial feasibility of the project.

CVHPA found BSRHS' pro forma financial statement and the projections it contains to be reasonable, noting that "[r]evenues appear to be conservatively estimated." BSRHS represents that, if the project is approved and moves forward in a timely manner, SFMC will be operational for the latter eight months of 2005, will incur an excess of expenses over revenues of $988,058 during those months, and will generate an excess of revenues over expenses of $1,877,635 in 2006.

CJW asserts that the financial feasibility of the St. Francis project is "questionable given Bon Secours' overly optimistic assumptions about its expected utilization and financial performance."

The evidence in the record indicates the existence of a public need for an acute care facility in western Chesterfield, an area experiencing considerable growth and residential development. BSRHS, which had total gross patient revenues exceeding $535.7 million in 1997, has the wherewithal and intent to meet that need and ensure the feasibility of the St. Francis project.

9. The relationship of the project to the existing health care system of the area in which the project is proposed; however, for projects proposed in rural areas, the relationship of the project to the existing health care services in the specific rural locality shall be considered.

SFMC would be situated along State Route 288, which bridges the population growth corridors leading into Powhatan and Amelia counties, and will, upon completion, proceed north to Goochland County and provide interstate-style access from across the Richmond metropolitan area. If SMFC were to be located beyond ten miles from CJW, perhaps located further west along U.S. Route 360 or U.S. Route 60, the public would not enjoy the same level of access. The proposed location of SFMC appears to be nearly optimal to serve the needs of the metropolitan area and identified rural areas.

10. The availability of resources for the project.

BSRHS is a well-developed system of health-related facilities and services that, in 1998, had $19.8 million in cash and cash equivalents and $86.4 million in total assets. BSRHS had total gross

patient revenues exceeding $535.7 million in 1997. BSRHS has adequate financial resources to implement and develop the operation of SFMC.

In additional written information following the 2002 IFFC, CJW asserts that, in 2001, the vacancy rate for registered nurses (RNs) was 11.9 percent and the vacancy rate for licensed practical nurses (LPNs) was 14.0 percent in central Virginia. Although CJW argues that SFMC will exacerbate the prevailing "heath care manpower shortage," the record indicates that BSRHS would be able to staff adequately SFMC without substantial adverse impact on the staffing of other health care facilities.

BSRHS estimates that SFMC will need 141 RNs and 24 LPNs. The record indicates that BSRMS's will expand its long-established nursing school, Bon Secours Memorial School of Nursing, from 26 graduates in 2001 to 100 by 2004. This school has a "work back" scholarship program, in which a nursing student agrees to work one year in return for each year of training he or she receives a scholarship. BSRMS represents that it engages in an active recruitment program, visiting high schools, arranging scholarships for students at a local community college, and seeking nurses practicing in Pennsylvania and Canada to relocate to central Virginia.

11. The organizational relationship of the project to necessary ancillary and support services.

BSRHS is a complex health system consisting of several facilities, including St. Mary's Hospital in Henrico County and MRMC in Hanover County. SFMC would operate as a constituent component of the Bon Secours system, having organizational access to in-house ancillary services and support from system-wide service departments.

12. The relationship of the project to the clinical needs of health professional training programs in the area in which the project is proposed.

The review of the St. Francis project in 1999 concluded that this consideration was not applicable.

At the 2002 IFFC, BSRHS presented evidence, discussed above in relation to the fourth statutory consideration, that the SFMC would directly benefit the Blackstone Family Practice Residency Program, affiliated with BSRHS and located to serve a rural area. The director of this program testified that SFMC would be a "facility in which we can consolidate current rotations," strengthen OB services in Blackstone, surrounding Nottoway County and other portions of this section of rural Virginia, help to supply primary care physicians for such rural areas and improve access to acute care services for the rural communities his residency serves.

CJW notes in a post IFFC submittal that "[a]lthough Bon Secours argued that the proposed hospital is necessary to support the Blackstone Family Practice Residency Program, this program has been in operation for 30 years without the proposed hospital. . . . The other hospitals in PD15 have been providing all necessary resources to support this program. There is no reason to believe the existing hospitals will not continue to provide all necessary support or that the proposed hospital is necessary for the viability of this program." This consideration calls for the Commissioner simply to

review any matters implicating a health professional training program when deciding whether to issue a certificate. It does not require a conclusion that a proposed project is necessary, or somehow essential, for the existence or continuation of a training program.

BSRHS has presented sufficient evidence to conclude that the St. Francis project would provide an appropriate clinical venue and educational opportunities for training family practitioners to serve in Virginia, and perhaps, to encourage and facilitate their long-term service in rural areas of the state where medical needs are keenly felt.

13. The special needs and circumstances of an applicant for a certificate, such as a medical school, hospital, multidisciplinary clinic, specialty center or regional health service provider, if a substantial portion of the applicant's services or resources or both is provided to individuals not residing in the health service area in which the project is to be located.

Not applicable.

14. The special needs and circumstances of health maintenance organizations. When considering the special needs and circumstances of health maintenance organizations, the Commissioner may grant a certificate for a project if the Commissioner finds that the project is needed by the enrolled or reasonably anticipated new members of the health maintenance organization or the beds or services to be provided are not available from providers which are not health maintenance organizations or from other health maintenance organizations in a reasonable and cost-effective manner.

Not applicable.

15. The special needs and circumstances for biomedical and behavioral research projects which are designed to meet a national need and for which local conditions offer special advantages.

Not applicable.

16. In the case of a construction project, the costs and benefits of the proposed construction.

The capital cost of the proposed construction, projected to total $69,500,000 in 1999, is currently projected to total $$74,479,700. This is a not an insubstantial capital expenditure. However, the evidence in the record demonstrates that the projected construction costs compare favorably with other recent similar projects that have received approval, including the accumulated cost of several improvements at CJW, discussed above.

BSRHS asserts that SFMC would engender considerable system-wide savings, mainly through its creation as a facility that presents a competitive challenge. BSRHS asserts that

> [w]hile the direct cost savings associated with receiving care at St. Francis (greater than $146 million in discounted present value) are sufficient to outweigh the costs of the construction project, additional savings are likely to result in the region from a reduction in [CJW's] demonstrably higher prices. Depending upon the magnitude of [CJW's] price reductions from their 1997 levels, the present value of such cumulative annual savings to the community (in the form of lower pricing from [CJW]) has been estimated to range from $159,319,300 (if the reduction is 5%) to as high as $795,645,340 (if the reduction is as much as 25%) over the life of the project. These savings dwarf the capital expenditure associated with this project and clearly demonstrate that the project is justified on a cost/benefit analysis.

The benefits associated with the proposed construction project include improved geographic and economic access for residents of the proposed primary and secondary service area populations. Renovation of SCH, closed and undergoing renovation to suit a non-medical purpose, is no longer a possible option for BSRHS and was not a viable one before its closure following issuance of the 1999 certificate. An additional alternative would involve spending over $38 million to augment BSRHS's St. Mary's Hospital in an attempt to enable it to absorb the closure of SCH. Such a project would underscore the concentration of acute care services in the urban and suburban area of PD 15 north of the James River, and would not offer the opportunity to introduce competition in the submarket area south of the James, or to yield the savings expected to accrue to the public. The benefits promised by the St. Francis project outweigh the construction costs associated with it.

17. The probable impact of the project on the costs of and charges for providing health services by the applicant for a certificate and on the costs and charges to the public for providing health services by other persons in the area.

In a September 27, 1999, report, Michael D. Pratt, Ph.D., disclosed his analysis of the economic effect the St. Francis project presents. Dr. Pratt noted that the James River causes "market segmentation" in PD 15, and creates "two, somewhat parallel, geographic submarkets." Further, according to Dr. Pratt,

> [t]he lack of competition on the South Side of the [James] River gives [HCA] leverage when it negotiates insurance and managed care contracts since South Side residents will want access to South Side hospitals and both of them are owned by [HCA]. The overall price structure set at [CJW] reflects the market power gained from being the sole provider of hospital services in a geographic submarket.

Dr. Pratt's analysis indicates that enhanced competition would have the effect of causing HCA, in particular CJW, to be more cost effective in the delivery of health care services.

At BSRHS's apparent request, PricewaterhouseCoopers, an international accounting and professional services firm, prepared a September 20, 1999, report that stated "[f]or the years 1994 through 1997, . . . [CJW] and Columbia-Richmond hospitals yielded an estimated $163 million and $282 million, respectively, in estimated possible 'free cash flows'." Dr. Noether, a consultant whose testimony BSRHS elicited at the 2002 IFFC, in commenting on HCA's profits, that "[o]ne would

expect that in a market that was competitive, reasonably competitive, even if not perfectly competitive, that prices received and profits enjoyed by a facility would not be particularly different from benchmarks reflecting other areas of the country that presumably are an average of more or less competitive areas."

Trigon Services, Inc., a subsidiary of Trigon Healthcare, Inc., now using the tradename Anthem Blue Cross and Blue Shield, wrote two letters in support of the St. Francis project. In its August 5, 1999, letter, Trigon noted its

> experience as an insurer that competition tends to lower cost to the health care consumer in an area. Today there is no competition south of the James River. Historically, in areas where there is no competition, hospital charges are much higher. Current hospital charges south of the river do reflect what we normally see in a non-competitive environment.

Trigon reiterated its support of the St. Francis project in a September 19, 2002, letter, seven days before the two-day IFFC to which both BSRHS and CJW were parties.

In a September 17, 2002, letter, CIGNA HealthCare, noting that it "represents 312,000 covered lives in Central Virginia," stated that CIGNA HealthCare's experience is

> . . . that the HCA Richmond hospitals' rates to date are competitive with the rates at [BSRHS's] hospitals and are lower than the rates paid to the [Virginia Commonwealth University,] Medical College of Virginia [Hospitals]. CIGNA HealthCare does not believe that the approval of . . . [SFMC] will necessarily lower CIGNA's payments to Richmond area hospitals.

In a September 26, 2002, letter, Aetna, Inc., another large national health insurance provider, stated its support of the St. Francis project and that its "best assessment" of the project is "that it will positively impact the price, quality and access to health care in Chesterfield and the greater Richmond area."[8]

BSSCH's present charge structure and that proposed for SFMC are substantially similar. St. Francis should be a cost effective provider offering competitive rates for its services, improving economic access for populations in the region through lowered costs and prices reflected in contracts with managed care entities and third-party payors.

[8] Aetna supports the St. Francis project despite some difficulty encountered in 1999 when BSRHS and Aetna sought to renew contractual terms for BSRHS's 2000 participation in Aetna's insurance programs.

18. Improvements or innovations in the financing and delivery of health services which foster competition and serve to promote quality assurance and cost effectiveness.

Both Trigon and Aetna have written the Commissioner, expressing those insurers' belief that construction of SFMC will lower health care costs and improve financing by providing competition in PD 15 south of the James River, although CIGNA, another large health care insurer, disagrees, and CJW argues that the St. Francis project "does not propose any innovation in financing and delivery of health services."

At the 2002 IFFC, BSRHS expert witness, Dr. Noether, noting the support of Trigon and Aetna, stated her opinion that SFMC would "enhance competition by providing competitive entry that will essentially foster greater competition both on price and quality dimensions." She stated that the basis of her opinion is her knowledge of basic economic principles, analysis embodied in antitrust policy, and an analysis of ". . . current market prices and profits earned by HCA that also suggest[] that the market is not completely competitive." Further, as Dr. Noether explains,

> . . . the area north of the James River where there are considerably more hospitals is more competitive than the are south of the river where only a single hospital with two campuses . . . [*i.e.*, CJW] exists. . . . The fact that HCA has the only facility south of the river makes it, gives it power in negotiating with managed care companies who need to be able to offer an attractive range of providers in order to be able to sell their plans, and essentially if they want to contract with a single hospital provider, HCA is their only option for giving them a network of hospitals located throughout the area. . . .

When asked to review a map identifying the overlapping service areas in which 75 percent of residents served by both HCA and BSRHS reside, Dr. Noether found it "quite evident" that BSRHS' service area

> is primarily north of the river, whereas the HCA service area because of its facility south of the river [*i.e.*, CJW] extends much more broadly, pretty much entirely overlaps Bon Secours' service area but extends well beyond it and provides much fuller coverage to employers who essentially are seeking good coverage for their employees in their negotiations with managed care plans.

The two areas appear, for certain purposes, to be "competitively distinct," as she describes and as suggested by an analysis of the provision of other, mainly commercial retail, services in PD 15, cited during the 2002 IFFC, that reveal a pattern of some duplication of resources, such as the location of retail facilities north and south, in order to cover the market area adequately.

19. In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities in the area similar to those proposed, including, in the case of rural localities, any distinct and unique geographic, socioeconomic, cultural, transportation, and other barriers to access to care.

CJW maintains that "[e]xisting inpatient hospital services satisfy the current public need. Three different hospitals have closed in the last two years, yet there is no undercapacity or shortfalls in available health care services. To the contrary, there remains relatively low [acute care] utilization in PD15 . . . [and] the proposed new hospital would merely duplicate the services already offered at [CJW]." Notably, the apparent low utilization of CJW has not led to a lack of profitability.

Even BSRHS concedes that within PD 15 "as a whole[,] there is an apparent excess of licensed hospital bed capacity," but it asserts further that "[t]he level of staffed bed occupancy suggests that such excess exists on paper more than anywhere else." Further, BSRHS asserts

> [a]nd, as more and more patient care is delivered in the outpatient setting, the level of inpatient occupancy becomes a less reliable indicator of the overall level of business experienced by a hospital. For these reasons, licensed occupancy levels below 85% do not by themselves demonstrate that Richmond area hospital resources are in fact underutilized.

Certainly, promoting an overabundance of resources runs counter to the spirit and intent of the law. But any supposed admonition, contained in this consideration, to respond with parsimony in response to the St. Francis case is far outweighed by the several benefits its authorization promises, including the prospect of greater efficiency borne of enhanced competition in an area occupied primarily by CJW.

20. The need and the availability in the health service area for osteopathic and allopathic services and facilities and the impact on existing and proposed institutional training programs for doctors of osteopathy and medicine at the student, internship, and residency training levels.

The review of the St. Francis project in 1999 concluded that this consideration was not applicable. CJW continues to assert that it is inapplicable.

The recent affiliation of the Blackstone Family Practice Residency with BSRHS, however, suggests that St. Francis would have a positive affect on an existing program for doctors at the "residency training level[]," by presenting the opportunity for training at SFMC in coordination with the Blackstone program. As discussed above in relation to the fourth and twelfth statutory considerations, the Blackstone program has graduated over 160 family physicians over the last 30 years. Two-thirds of these graduates have gone to practice in rural areas and two thirds of them have remained in Virginia, according to BSRHS. The residency program accommodates 18 residents annually, and each must attend 40 obstetric deliveries. The St. Francis project would directly benefit and serve the need for this institutional training program.

III. RECOMMENDATION.

I have reviewed the application of Bon Secours Richmond Health System (BSRHS) to replace and relocate Stuart Circle Hospital (SCH) to western Chesterfield County, where it would become St. Francis Medical Center (SFMC), within planning district (PD) 15. I have reviewed and analyzed the entire administrative record regarding this matter, opened on July 1, 1999, and closed on November 8, 2002. The record consists of many documents, including all submissions made by BSRHS,

submissions made by Chippenham & Johnston-Willis Hospitals (CJW), a party to this matter by virtue of having shown good cause.

In September 2002, I conducted a two-day informal fact-finding conference (IFFC) at which both BSRHS and CJW, by counsel, presented written and testimonial evidence supporting their positions. I have reviewed the transcript of that two-day IFFC. I have considered the recommendation of the board of directors of the Central Virginia Health Planning Agency (CVHPA), which recommended conditional approval of the St. Francis project.

Based on my assessment of the record in its entirety, and in light of the applicable law relating to this matter, I have concluded that:

(i) Three provisions of the State Medical Facilities Plan (SMFP), *i.e.*, those contained in Subpart (iii) of Subsection B 1 of 12 VAC 5-240-30 (relating to availability and off-site replacement of acute care services), Subsection A 2 of 12 VAC 5-240-50 (relating to cost and a geographical distance standard), and Subsection C of 12 VAC 5-250-40 (relating to utilization of obstetric services) should be set aside, pursuant to Subsection A of Section 32.1-102.3 of the Code of Virginia based on sufficient appropriate evidence, discussed above; and

(ii) The proposed replacement and relocation of Stuart Circle Hospital through the construction of St. Francis Medical Center MERITS APPROVAL and should receive a certificate of public need (COPN), subject to the conditions proposed in December 1999, to which BSRHS has agreed.

Several decisions issued by the Commissioner over the last 25 years, including the five decisions authorizing relocations cited above, have looked squarely at whether the hospital proposed for replacement has a facility-based need to be replaced, often due to physical obsolescence, and whether the resulting proposal for replacement is reasonable in scope, in location and in cost. I believe the St. Francis project satisfies these issues, is consistent with the remaining provisions of the SMFP, offers considerable benefits to the health care system of PD 15, and promises the overarching benefit of meeting a demonstrated public need.

The specific reasons for my recommendation include:

(i) BSRHS has demonstrated that (a) Stuart Circle Hospital needs to be replaced, *i.e.*, its physical plant – old, landlocked, and designed overwhelmingly for providing health care according to an inpatient model – displays an obsolescence that cannot reasonably be addressed through renovation, and (b) the proposal to relocate the hospital to Chesterfield County, through construction of St. Francis Medical Center, is reasonable in scope, location and cost;

(ii) The board of directors of CVHPA, along with the Capital Area Health Advisory Council (CAHAC), has recommended conditional approval of the St. Francis project;

(iii) The St. Francis project would be consistent with the remaining applicable provisions of the State Medical Facilities Plan (SMFP);

(iv) The St. Francis project would meet a public and local need for acute care services in the intended service area, mainly in western Chesterfield County – an area that is experiencing substantial growth and development, and the counties of Amelia and Powhatan, which are primarily rural;

(v) The proposed project, to be located proximate to State Route 288, would increase direct public accessibility to acute care services in the area, part of which is rural, and would result in better distribution of acute care services regionally;

(vi) Two large third-party payors support the St. Francis project in their strong belief that it would reduce health care costs by presenting beneficial competition;

(vii) No less costly or more effective alternatives to the proposed project exist, the project is feasible and BSRHS possesses adequate resources to implement the project successfully; and

(viii) The St. Francis project would inject an element of beneficial competition in PD 15 and address strong indications of market concentration, relating to two geographically-distinct areas of behavior within a larger economic market, thereby promising several benefits, including lower costs and prices, and greater accessibility to, quality of and efficiency in rendering health care services.

Respectfully submitted,

January 27, 2003

Douglas R. Harris, J.D.
Adjudication Officer